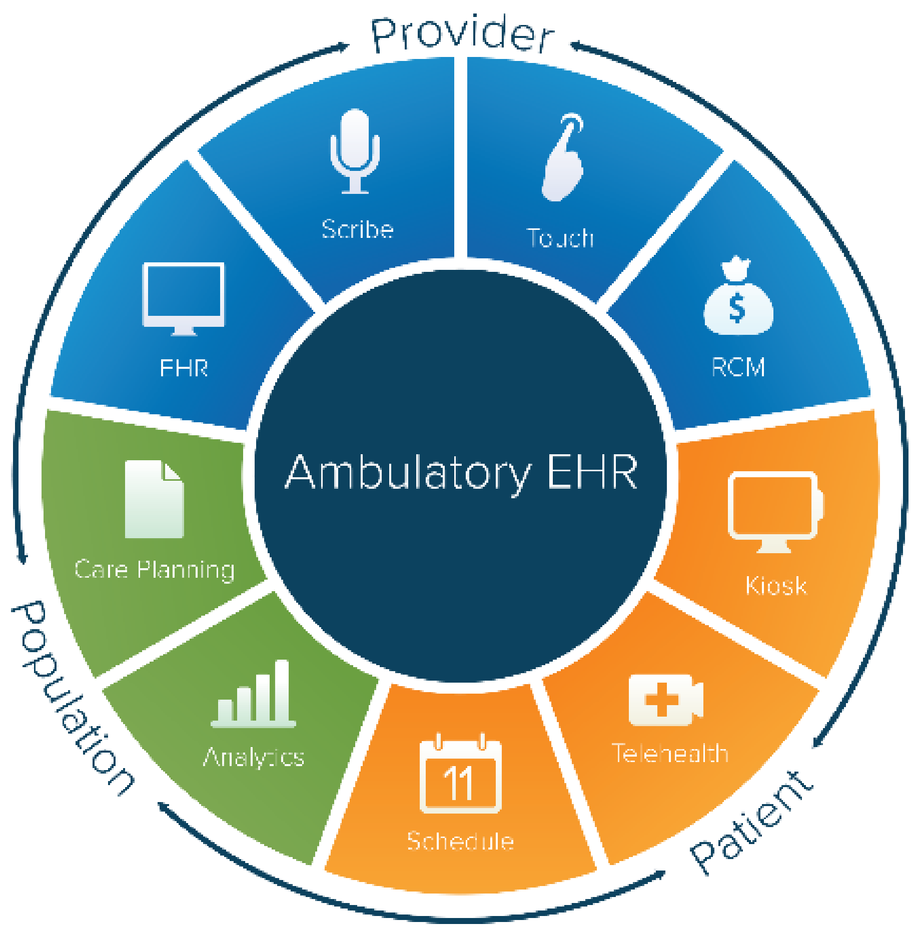
eClinicalWorks

Business Analysis Department

END USER WORKBOOK—EMR III

Kentucky Department for Public Health—March 2017



Contents

EMR III WORKFLOWS

The following sections describe the end user EMR III workflows.

For more information about these workflows, and V10e, refer to the *eCW 101 EMR III Workbook* and the documentation available on the my.eclinicalworks.com Customer Portal.

> **Note:** For information about patient safety, refer to the Patient Safety Advisory Letter, available on the my.eclinicalworks.com Customer Portal.

Advance EMR Features

Progress Notes Templates

Providers can create generic and patient-specific templates.

Using Progress Notes Templates

Path: *Progress Notes > Arrow next to Templates > Copy and Merge from Templates*

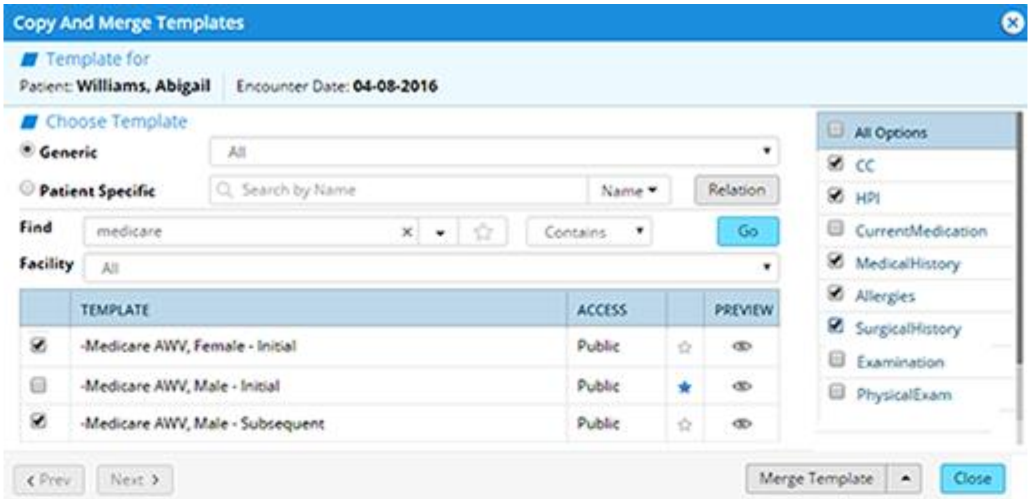
Copy or merge templates to the Progress Notes. Merging adds the template to the Progress Notes without overwriting any data that was in that section. Copying a template overwrites, and replaces a section of the Progress Notes with the template.

To copy, or merge a template:

1. Select the *Generic* or *Patient Specific* radio button.
2. In the *Find* field, enter the keyword of the template, and click *Go*.

   The list of templates displays.
3. Check the box next to the template.

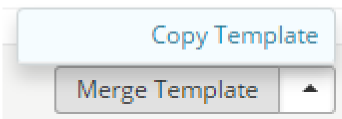
4. Check the box for the section name (*e.g.*, HPI, Current Medication, *etc.*):



5. Click *Merge Template*.

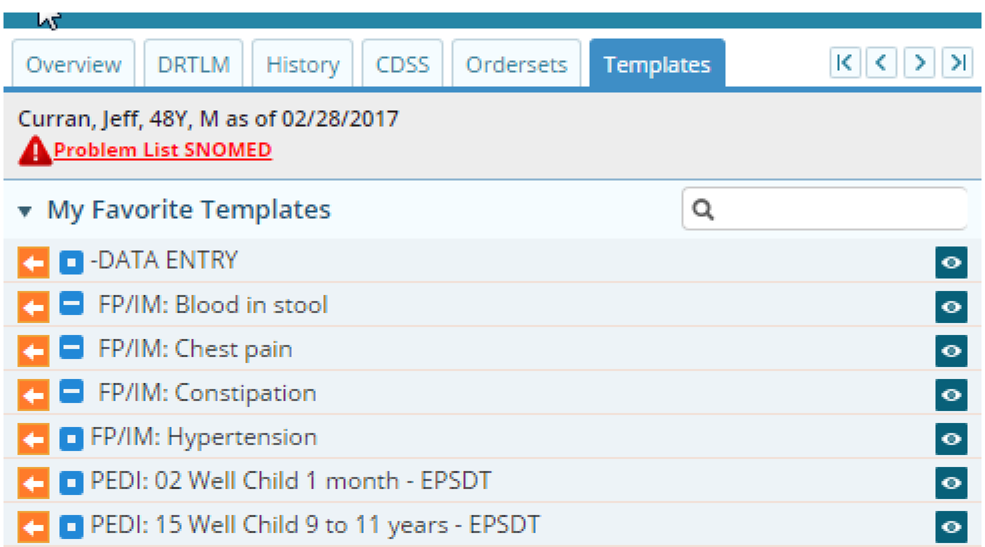
   OR

   Click the arrow next to Merge Template, and then click *Copy Template*:



Merging Templates from the Right Chart Panel

Favorites templates can be merged from the right chart panel by clicking on the "Templates" tab.



1. Choose the Template from the favorite list.
2. The magnifying symbol, allows the user to view the information in the template.

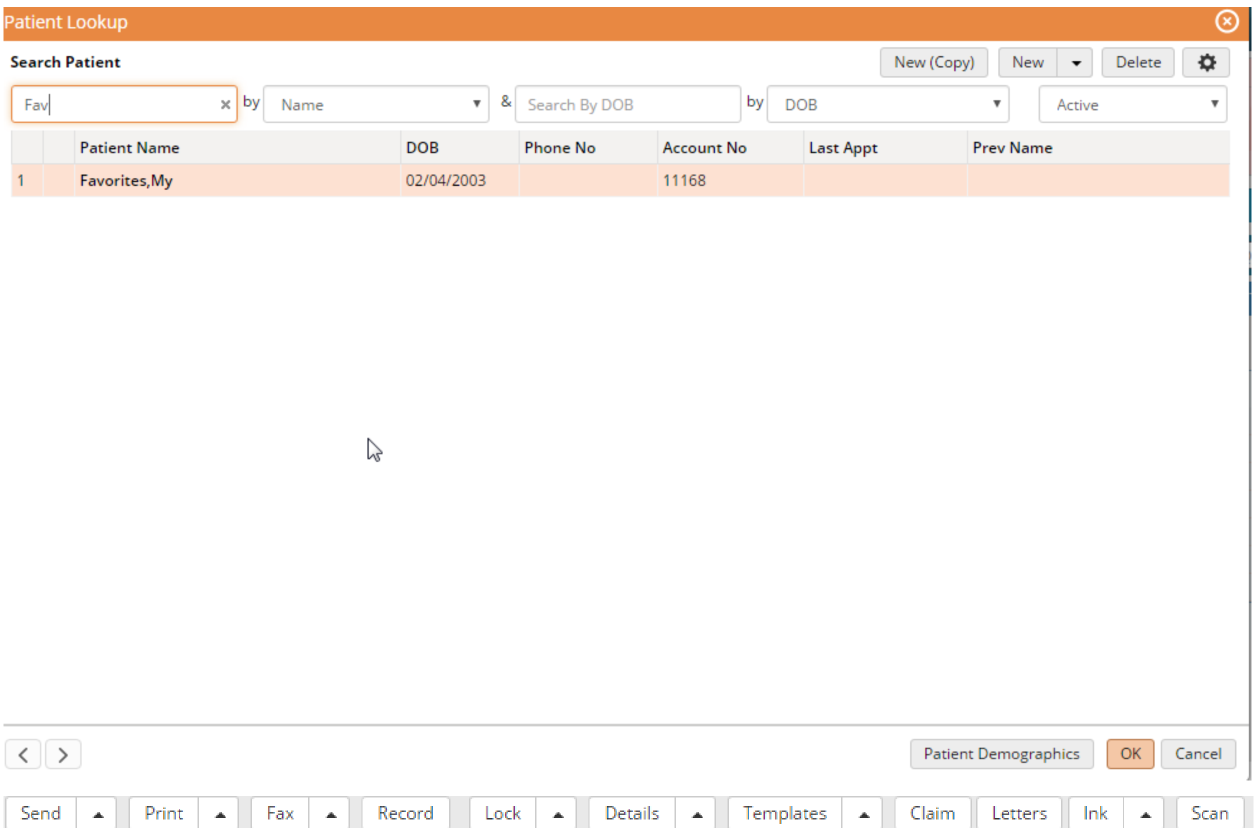
3. Clicking on the arrow will "Merge" the template and insert the information from the selected template into the current progress note.

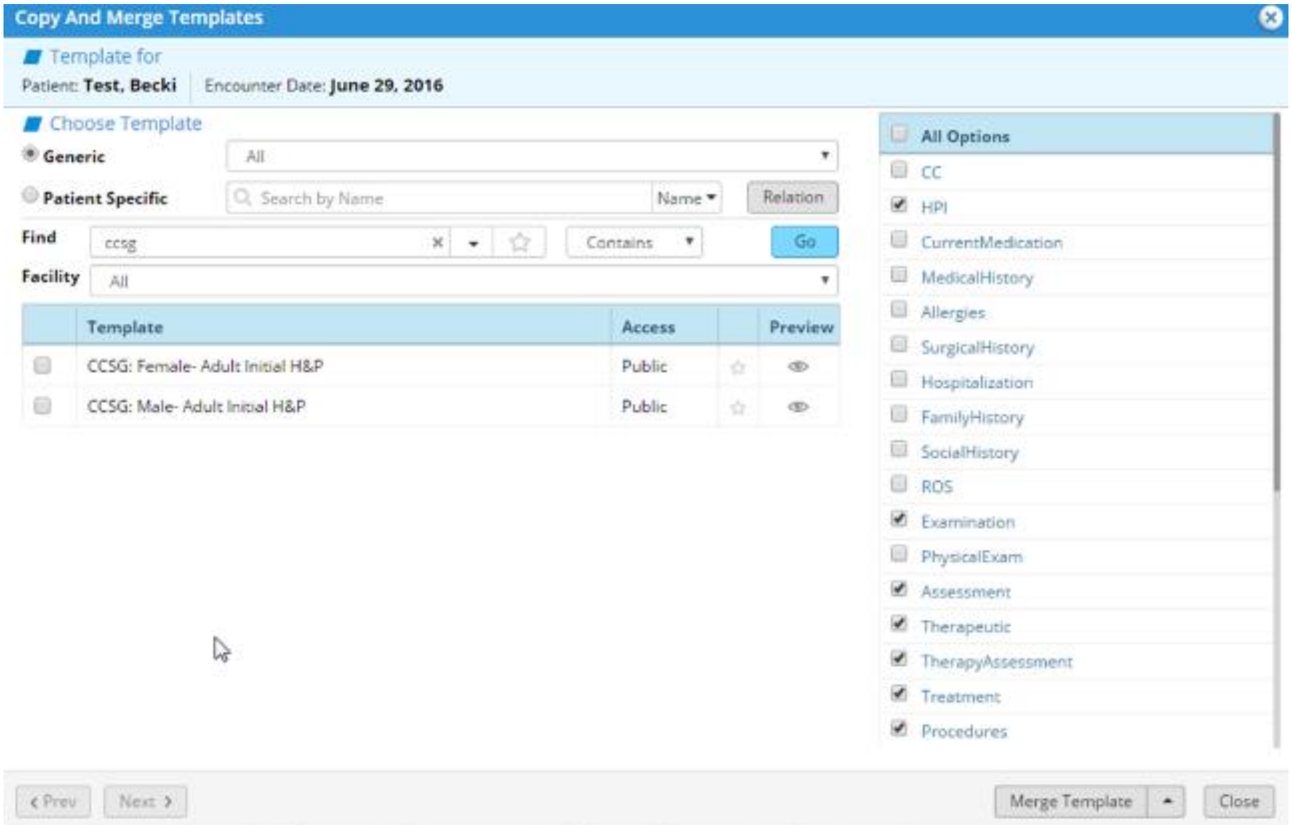
> **Note:** Note: Using Templates from the Right Chart Panel allows the user to only "Merge" the template.

Adding Favorite Templates

Favorite templates can be added by clicking on the "Templates" button at the bottom of the progress note.

1. From the patient look up window, search for the 'patient' labeled as 'My Favorites' and go to a progress note.
2. From the progress note click on 'Templates' button on the bottom.





3. Choose the Template Type as Generic & Category as 'All'.
4. Search for 'CCSG' in the 'Find' box to pull up all the CCSG templates.
5. Select the desired template and click (star symbol). This will add the template to the users favorite list.
6. Once saved, user can exit out of the patient 'My Favorites'.

Below is a list of templates that have been created for Kentucky Department for Public Health:

eCW Template Name	DPH Form Name (if applicable)
Tobacco Counseling Sheet	N/A - Health Promotion Branch requirements
HANDS Referral Record Screen	N/A - Early Childhood Development Branch requirements
Diabetes Self-Mgmt Edu Referral	N/A - Diabetes Prevention and Control Program Requirements
HCV Infection Risk Assessment	HCV 2
Health Equity Questionnaire	E Clinical Works Health Equity Module-ayedits (4)

eCW Template Name	DPH Form Name (if applicable)
CCSG: Adult Initial H&P- Female	H&P 13 Initial (Adult)
CCSG: Adult Initial H&P- Male	H&P 13 Initial (Adult)
CCSG: Adult Interval H&B- Female	H&P 14 Interval (Adult)
CCSG: Adult Interval H&B- Male	H&P 14 Interval (Adult)
CCSG: Domestic Violence Documentation	DV/SA-1 Domestic Violence/Sexual Assault Documentation Form
CCSG: Sexual Assault Documentaion	DV/SA-1 Domestic Violence/Sexual Assault Documentation Form
CCSG: Peds Initial H&P- Female	H&P 13 Initial (Pediatric)
CCSG: Peds Initial H&P- Male	H&P 13 Initial (Pediatric)
CCSG: Peds Interval H&P- Female	H&P 14 Interval (Pediatric)
CCSG: Peds Interval H&P- Male	H&P 14 Interval (Pediatric)
CCSG: Resupply Visit Form	BC-1 Resupply Visit Form
CCSG: Pregnancy Test Visit	PT-1 Pregnancy Test Visit Form
CCSG: Positive Pregnancy Test Only	PT-1 Pregnancy Test Visit Form
CCSG: Negative Pregnancy Test Only	PT-1 Pregnancy Test Visit Form
CCSG: STD 1 Female	STD-1 Sexual History and Physical Exam Form
CCSG: STD 1 Male	STD-1 Sexual History and Physical Exam Form
CCSG: Immunization Only Visit	GR208 & Barren River IMM-1
Dental- Preventive Adult High Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Adult High Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Adult Low Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Adult Low Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Adult Moderate Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements

eCW Template Name	DPH Form Name (if applicable)
Dental- Preventive Adult Moderate Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child High Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child High Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child Low Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child Low Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child Moderate Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child Moderate Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Visit	N/A - Dental Hygiene Program Requirements
Dental- Screening Only	N/A - Dental Hygiene Program Requirements
Dental- Varnish Only Visit	N/A - Dental Hygiene Program Requirements
Dental- Varnish Only Visit Codes Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Varnish Only Visit Codes Normal Findings	N/A - Dental Hygiene Program Requirements
Dental-Sealant Only Visit	N/A - Dental Hygiene Program Requirements
EBLL- BLL>25	KCLPPP Case Management Follow Up Report Form
EBLL- Education	KCLPPP Case Management Follow Up Report Form
EBLL- Environmental	KCLPPP Case Management Follow Up Report Form
EBLL- Follow-Up	KCLPPP Case Management Follow Up Report Form

eCW Template Name	DPH Form Name (if applicable)
EBLL- Referrals	KCLPPP Case Management Follow Up Report Form
TB H&P-13	TB H&P-13 TB Clinic Initial Health Assessment/History/Exam
TB-1 Infection Form	TB-1 Infection Form
TB-4 Risk Assessment	TB-4 TB Risk Assessment Form
TB-17 DOT Initial Phase	TB-17a DOT Record Initial
TB-17 DOT Continuation Phase	TB-17b DOT Record Continuation
TB-20 TB Clinic Follow-up	TB-20 TB Clinic Follow-up Visit
Oral Health KIDS Smile	OH-11 KIDS Smile (personal record)
KWCSP - Breast Screening	ACH-58 Cancer Screening Form
KWCSP Cervical Cancer Screening	ACH-58 Cancer Screening Form
Bright Futures Well Child 2-5 days	Bright Futures Infancy Core Tools
Bright Futures Well Child 1 month	Bright Futures Infancy Core Tools
Bright Futures Well Child 2 months	Bright Futures Infancy Core Tools
Bright Futures Well Child 4 months	Bright Futures Infancy Core Tools
Bright Futures Well Child 6 months	Bright Futures Infancy Core Tools
Bright Futures Well Child 9 months	Bright Futures Infancy Core Tools
Bright Futures Well Child 12 months	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 15 months	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 18 months	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 2 years	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 2.5 years	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 3 years	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 4 years	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 5 to 6 years	Bright Futures Middle Childhood Core Tools
Bright Futures Well Child 7 to 8 years	Bright Futures Middle Childhood Core Tools
Bright Futures Well Child 9 to 10 years	Bright Futures Middle Childhood Core Tools

eCW Template Name	DPH Form Name (if applicable)
Bright Futures Well Child 11 to 14 years	Bright Futures Adolescence Core Tools
Bright Futures Well Child 15 to 21 years	Bright Futures Adolescence Core Tools
School Health: Burns	GR207
School Health: Ear, Nose, and Throat	GR202
School Health: Head Check	GR205
School Health: Head Injury	GR206
School Health: Headache	GR204
School Health: Immunization	GR208
School Health: Insect Bite/Sting	GR209
School Health: Negative Pregnancy	GR203
School Health: Psychotropic Med/Assess	GR201
School Health: Asthma/Respiratory Assessment	GR210
School Health: GI Assessment	GR211
School Health: Tracheotomy Care	GR212
School Health: Skin Irritations	GR213
School Health: Wounds	GR214
School Health: Eye Assessment	GR215
School Health: Nose Bleed	GR216
School Health: Screenings	GR217
School Health: Gastrostomy Care/Feeding	GR218
School Health: Catheterization	GR219
School Health: Hypo-Hyperglycemic Assessment	GR222
School Health: Seizure	GR223
School Health: Muscle/Bone/Joint Pain or Injury	GR225

eCW Template Name	DPH Form Name (if applicable)
School Health: Menstrual Cramps	GR227
School Health: Oral Assessment	GR228
School Health: Heat Exposure	GR230
MNT-Adult	MNT-Adult
MNT-Pediatric	MNT-Pediatric
MNT-Diabetes	MNT-Diabetes
MNT-Gestational Diabetes	MNT-Gestational Diabetes
MNT-Renal	MNT-Renal
MNT-Follow-Up	MNT-Follow UP

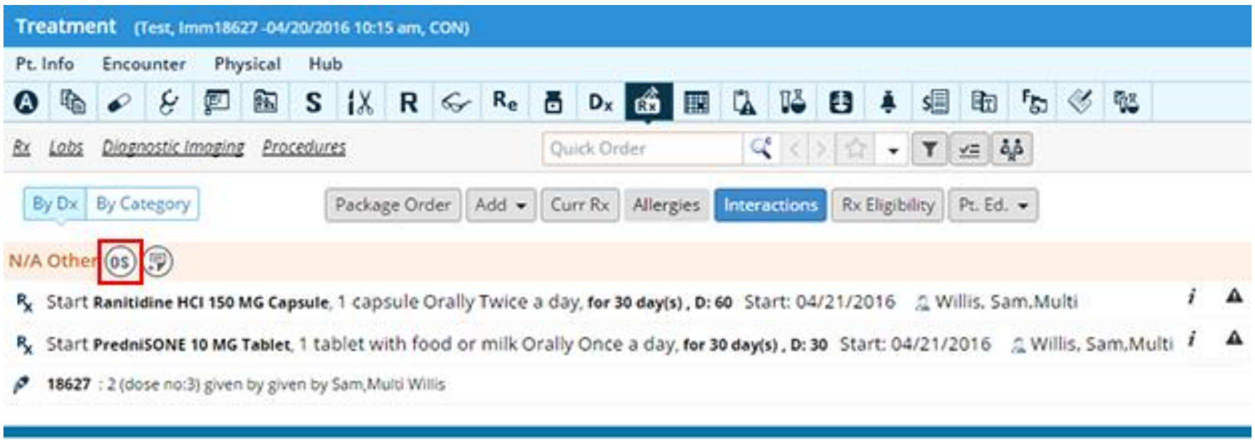
Order Sets

Using Order Sets from the Progress Notes

Path: *Progress Notes > Treatment > OS icon*

OR

Progress Notes > ICW > Order Sets



The following table describes the information in this window:

Area	Description
Order Set drop-down list	Select an Order Set
Select All button	Select the entire Order Set
First check box in the heading	Select an entire section, check the first box in the heading column. After, all items in the section are highlighted, click *Order*.
Check box next to an item	Select an individual item in a section.

Accessing Order Sets from ICW

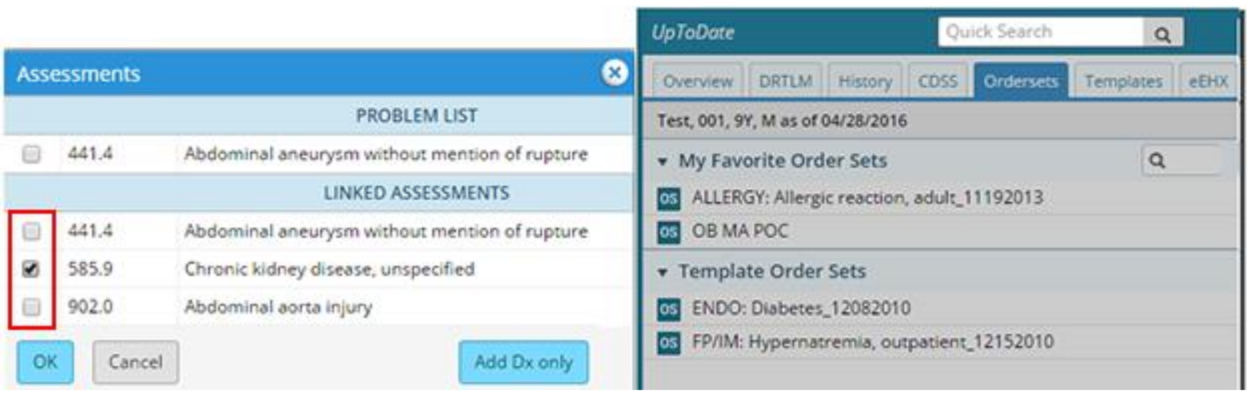
Path: *Progress Notes > ICW > Order Sets*

Access an order from the ICW when it is added to the provider's favorites list, or associated with a Progress Notes template.

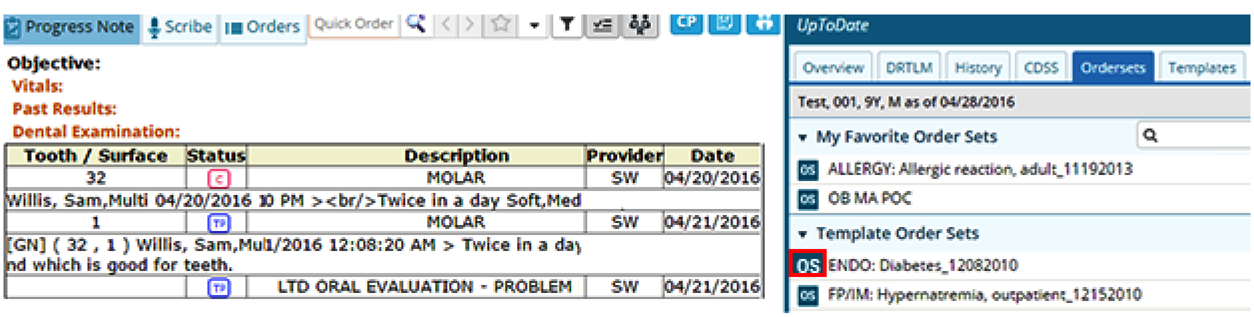
Note: The OS tab must be enabled to use this feature: Menu > File > Settings > My Settings > Show/Hide

To access an Order Set from Interactive Clinical Wizard (ICW):

1. Click the *OS* icon next to the Order Set.
2. The list of trigger diagnosis codes displays in the Linked Assessments window:



3. Check the box next to the diagnosis code.
4. Click *OK*.
5. To merge or copy Order Sets associated with Progress Notes templates, click the *OS* icon next to the template Order Set:



Below is a list of order sets that have been created for Kentucky Department for Public Health.

eCW Order Set Name
CCSG: Well Child Pt Edu – Infancy (0mo-11mo)
CCSG: Well Child Pt Edu – Early Childhood (12mo-4yr)
CCSG: Well Child Pt Edu – Middle Childhood (5yr-10yr)

eCW Order Set Name
CCSG: Well Child Pt Edu – Adolescence (11yr-21yr)
CCSG Domestic Violence Pt Edu
CCSG Family Planning
CCSG General Pt Edu
CCSG HIV Pt Edu
CCSG Immunizations
CCSG Lead Pt Edu
CCSG Oral Health Pt Edu
CCSG Points to Remember Pt Edu
CCSG Prenatal Pt Edu
CCSG Sterilization Pt Edu
CCSG Tobacco Pt Edu
Diabetes Patient Resources
Hepatitis C Virus Teaching Sheets

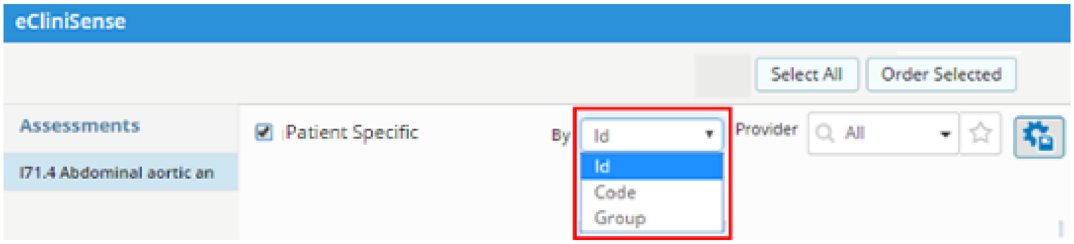
eCliniSense

Path: *Progress Notes > Treatment*

eCliniSense enables providers to review treatment (medications, labs, diagnostic imaging tests, or treatment notes) ordered previously for a particular diagnosis. Providers may choose to use a part, or the entire treatment in the current treatment plan.

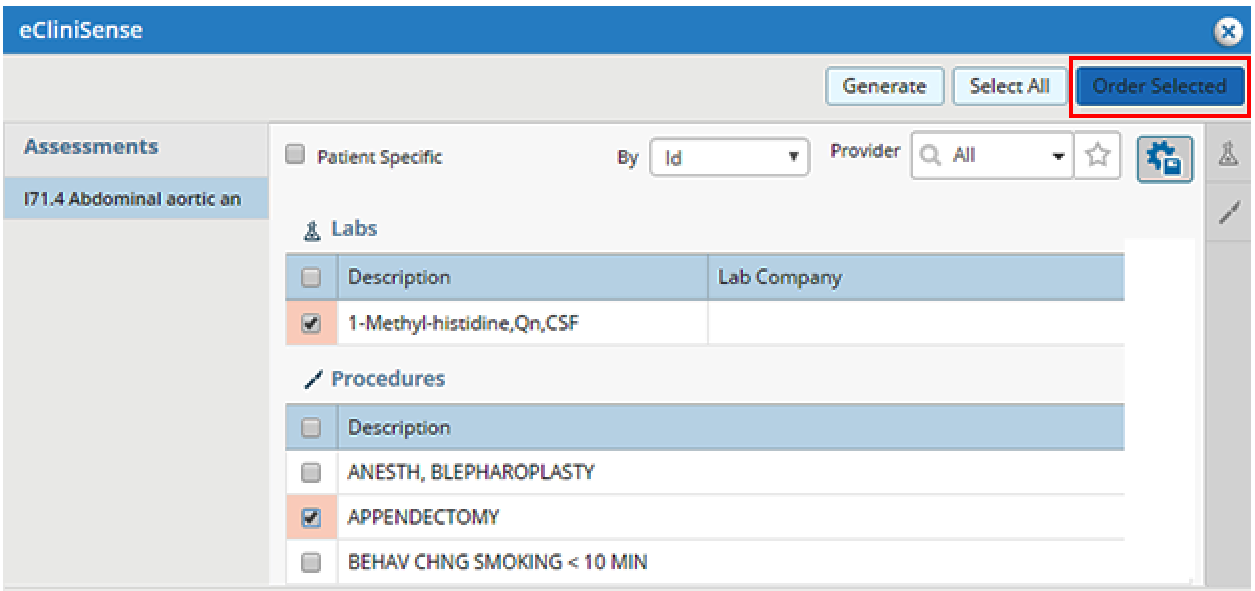
To use eCliniSense from the Treatment window:

1. Next to the treatment category, click the eCliniSense icon:
2. Click the assessment in the left pane.
3. Search the eCliniSense information using the *By* drop-down list:
   - By *ID* to generate for a specific ICD name.
   - By *Code* to generate for a particular ICD-10 code (*e.g.*, E11).
   - By *Group* to generate for entire ICD 10 group (*e.g.*, E11):



4. Generate eCliniSense for that particular patient by checking the *Patient Specific* box.
5. From the *Provider* drop-down list, select the provider.
6. Click *Generate*.

   The list of treatment displays.
7. Select the treatment by checking the boxes next to the description.
8. Click *Order Selected*:



The treatment is added to current Treatment section

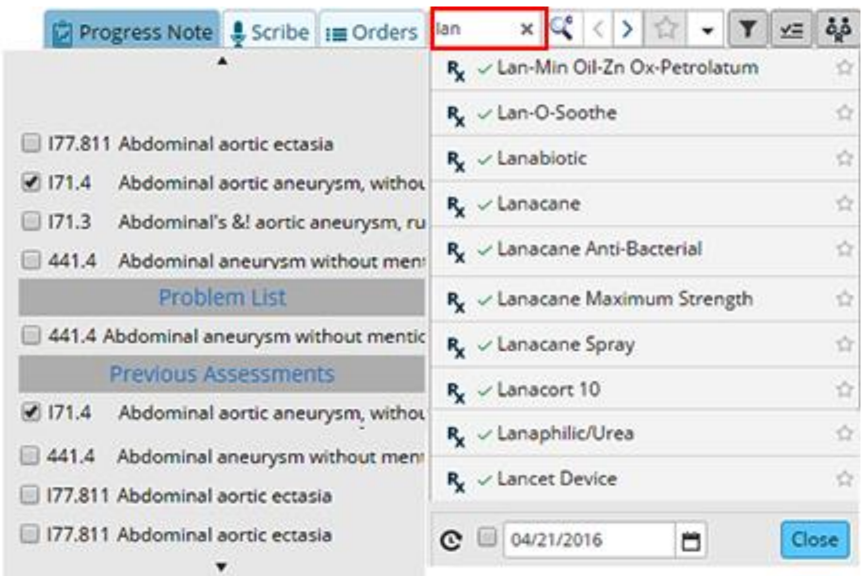
Quick Search

Path: *Progress Notes > Quick Search field*

The Quick Search populates from the Previous Assessments ordered and Problem List. There is an arrow at the top and end of the list, click to view the rest of the list. Order labs, DI, procedures, immunizations, injections, and medications, and associate them with patient's assessments.

To use Quick Search:

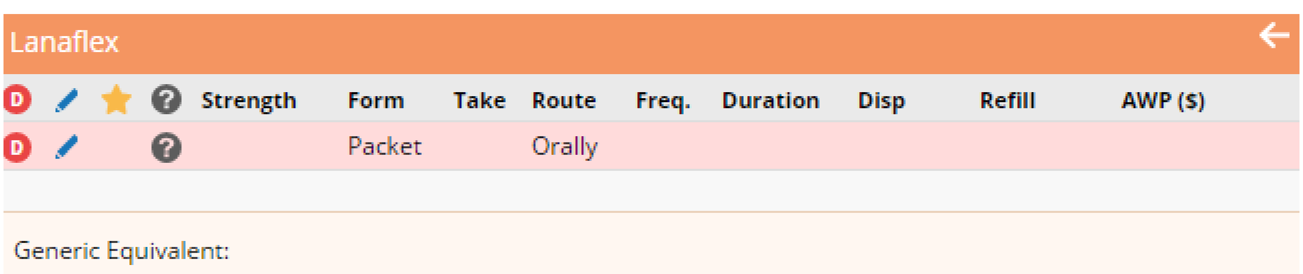
1. Enter the search text in the Quick Search field:



The Problem List and Previous Assessments display.

2. Check the box next to the assessment and click the order.

   The order window opens:



3. Click the name of the order.

   The order is added to the Progress Notes.

Patient Dashboard Options

Accessing the Patient's Demographic Information and Patient Hub

The Info button in the Patient Dashboard enables access to detailed patient demographic information and the Hub button enables access to the Patient Hub.

To access Patient Information and Hub:

From the Patient's dashboard, click *INFO* to access the patient's demographic information, or *HUB* to open the Patient Hub:

Printing and Faxing Medical Summary

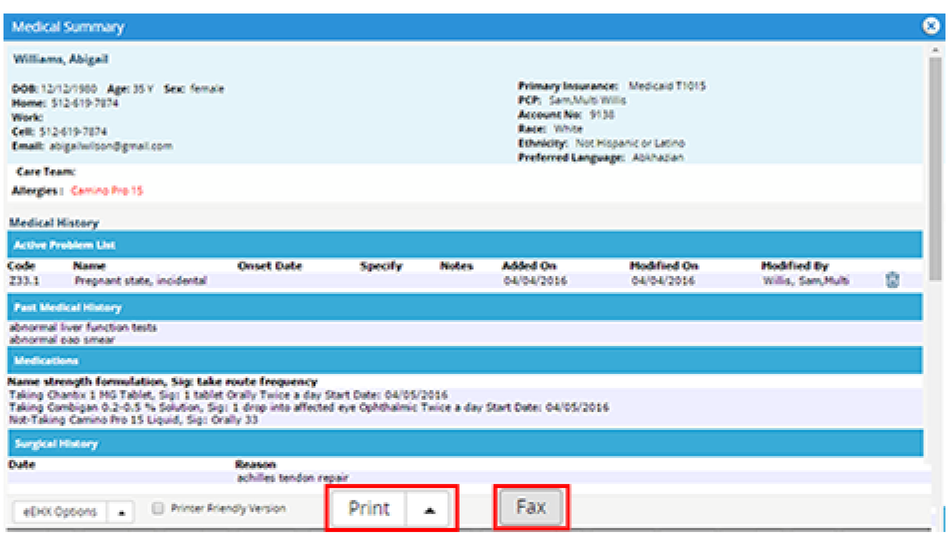
Path: *Progress Notes > Medical Summary link*

OR

Patient Hub > Medical Summary

To print or fax Medical Summary:

1. From the Medical Summary window, click the arrow next to *Print*.
1. Click Print/Fax Options.
2. Select the categories to include in the medical summary by checking the boxes.
3. Click *Print* or *Fax*:



Viewing Patient Encounters

Path: *Patient Hub > Encounters icon*

OR

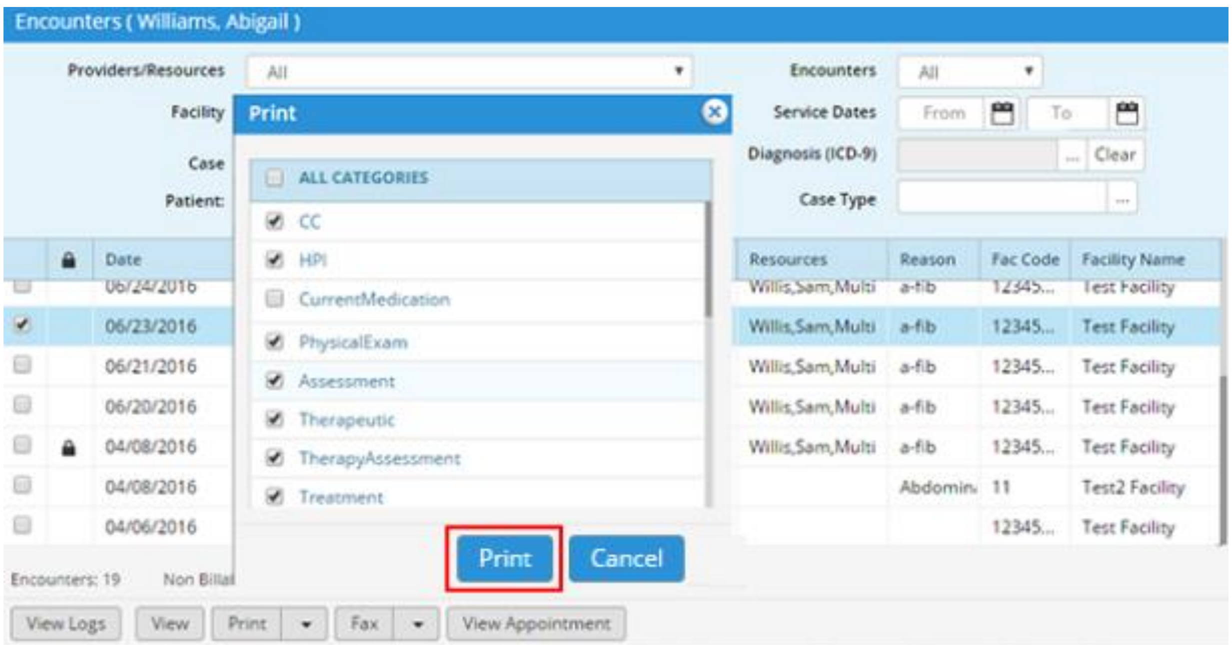
Patient Dashboard > Encounters tab

Printing and Faxing Patient Encounters

Path: *Patient Hub > Encounters*

To print patient encounters:

1. From the Encounters window, select an encounter, click the arrow next to the *Print* button, or *Fax* button.
2. Select categories to print or fax by checking the boxes:



3. Click *Print* or *Fax*.

Viewing Scanned Documents

Path: *Patient Dashboard > Patient Docs link*

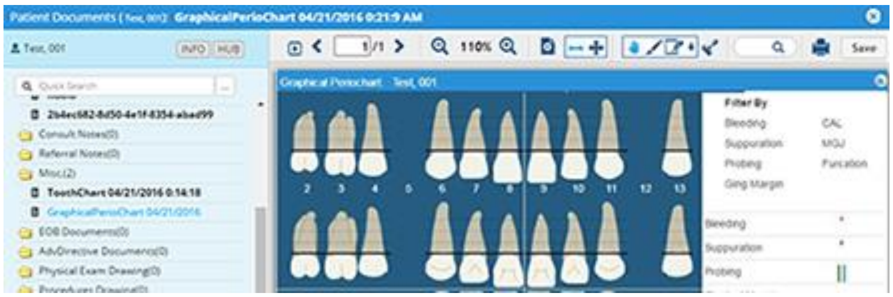
OR

Patient Hub > Patient Docs

To view scanned documents:

1. Click the name of the document from the folders list in the left pane.

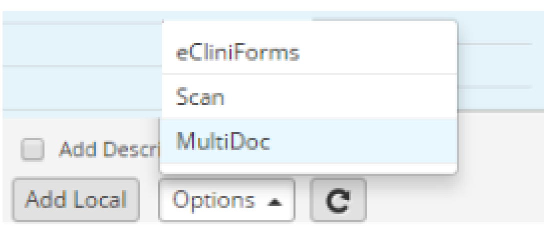
   The document displays in the right pane:



Printing and Faxing Scanned Documents

To print or fax multiple scanned documents:

1. From the patient documents window, click *Options*.
2. Click *MultiDoc*:

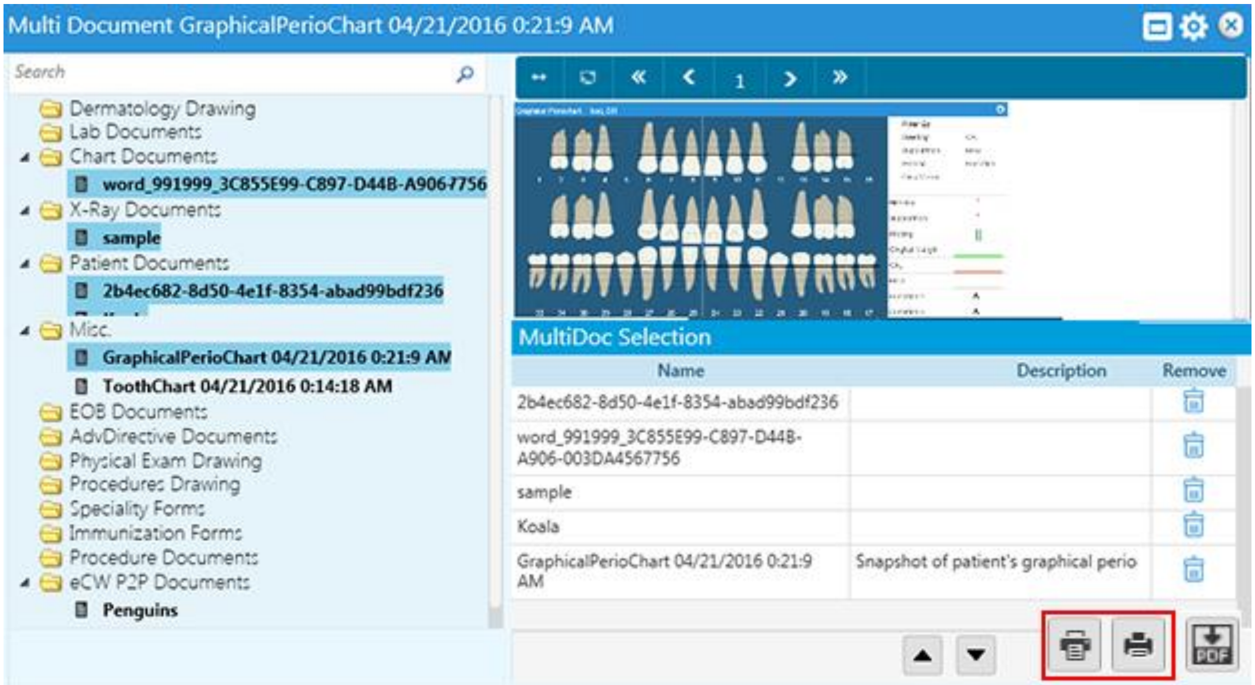


   The Multi Document window opens.

3. Select the needed files from the list.

   The preview of the last selected document and the selected files display in the right pane:

4. Click *Fax* or *Print*:



Viewing Patient Flowsheets

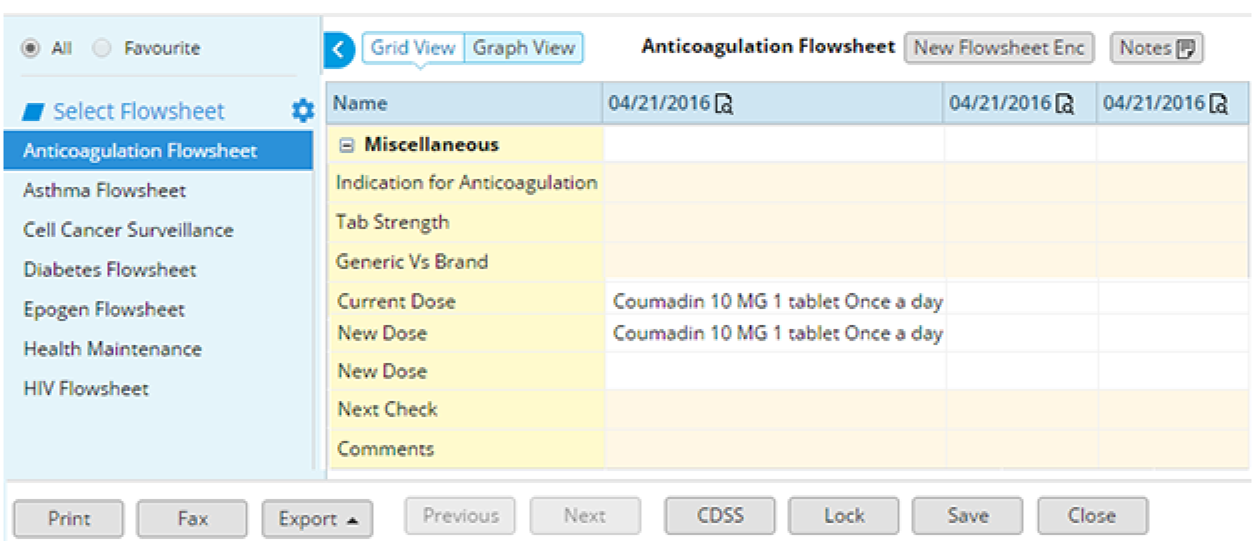
Path: *Patient Dashboard > Flowsheets link*

OR

Patient Hub > Flowsheets

To view Flowsheets:

1. In the Select Flowsheet list, click the name of the Flowsheet.
2. The Flowsheet displays in the right pane:



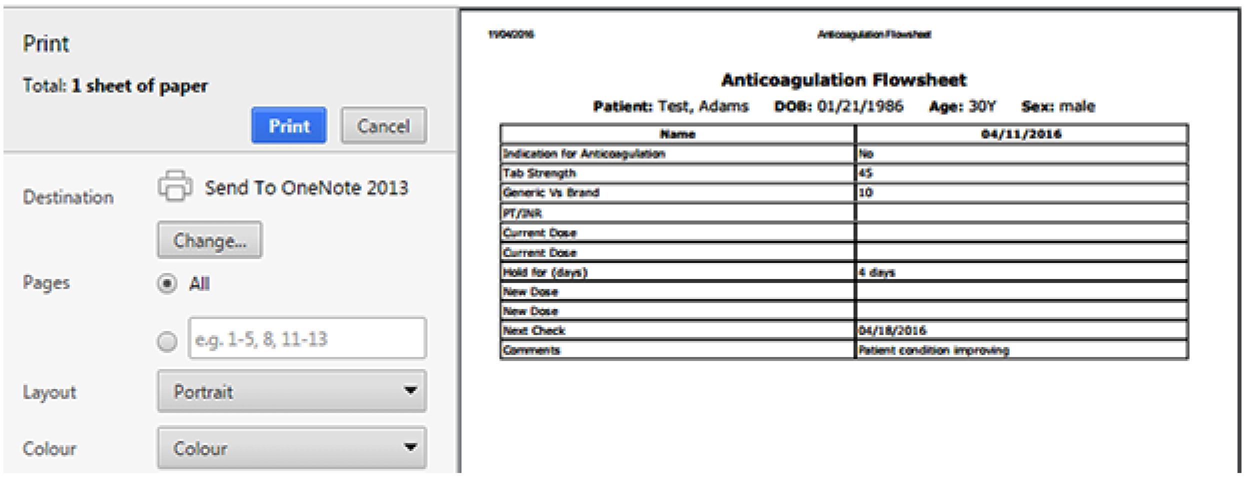
3. The yellow fields are items populated from the Progress Notes.
4. View Flowsheet in *Grid View* and *Graphical View*.
5. Enter notes in white fields next to the Flowsheet items.
6. Click *Save* to save the flowsheet.
7. Click *Lock* to lock the Flowsheet after editing.
8. Print, fax, or export the Flowsheet as a CSV file.

Printing and Faxing Flowsheets

To print the Flowsheet:

1. From the select Flowsheet window, click *Print*.

   The print preview window opens:



2. Adjust the settings as needed.
3. Click the *Print* button to print the Flowsheet.

   OR

   Fax the Flowsheet to the pharmacy:

   a. From the select Flowsheet window, click *Fax.*
   b. From the Pharmacy Lookup window, select a box by checking the box, and click *OK*.

      The Fax Documents Preview window opens.

   c. Review the sender, recipient details, and then click *Send Fax.*

      The Flowsheet is sent to the pharmacy.

Interactive Clinical Wizard (ICW) Options

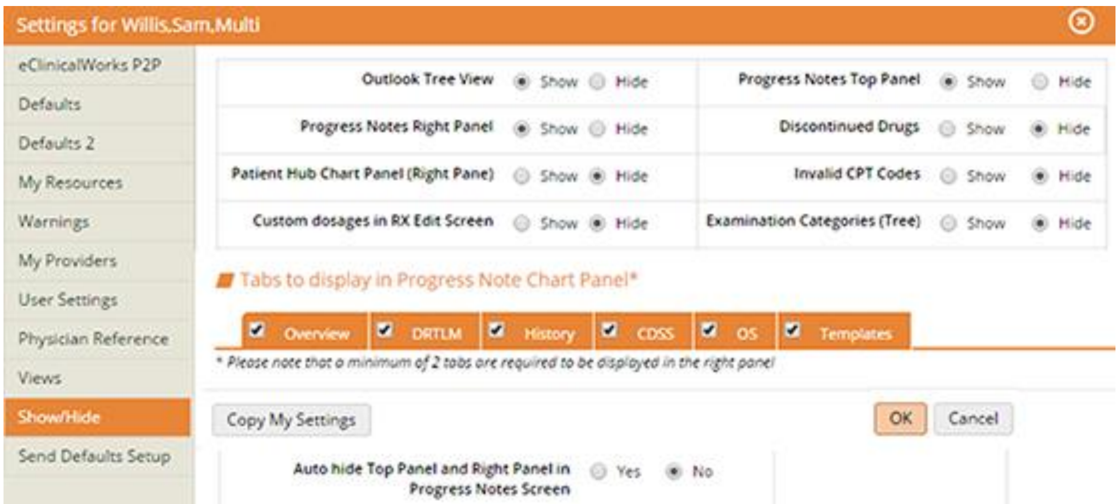
Accessing and Customizing the ICW

Path: *Main Menu > eCW Menu > File tab > My Settings > Show/Hide*

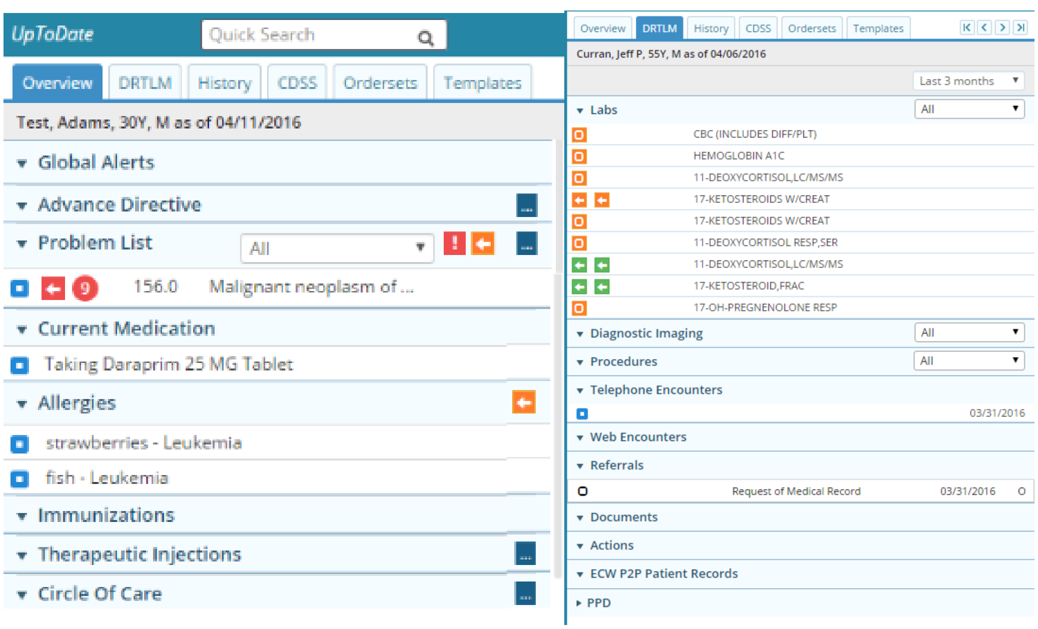
Select the tabs that display in the Interactive Clinical Wizard (ICW). A minimum of two tabs are mandatory in the ICW.

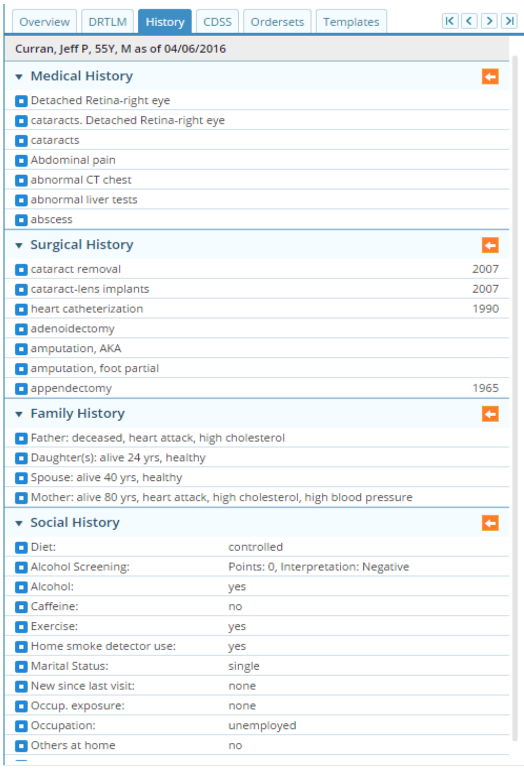
To customize ICW:

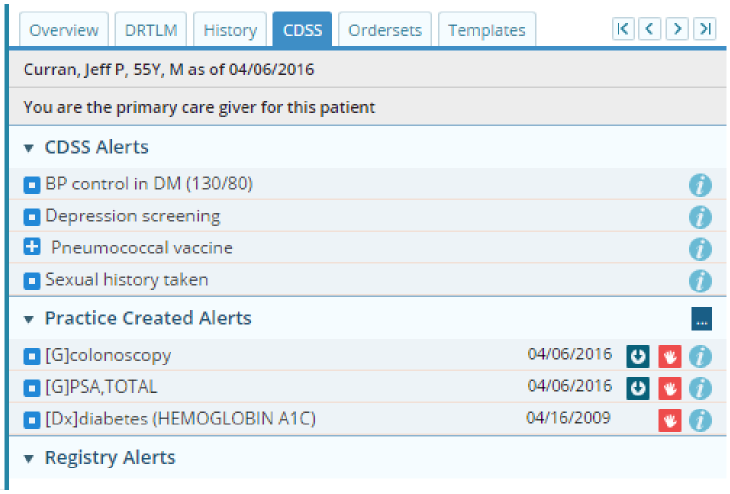
1. For each of the options, select the *Show* or *Hide* radio button.
2. In the *Tabs to display in Progress Note Chart Panel* section, check the box next to each tab to display it in the ICW:

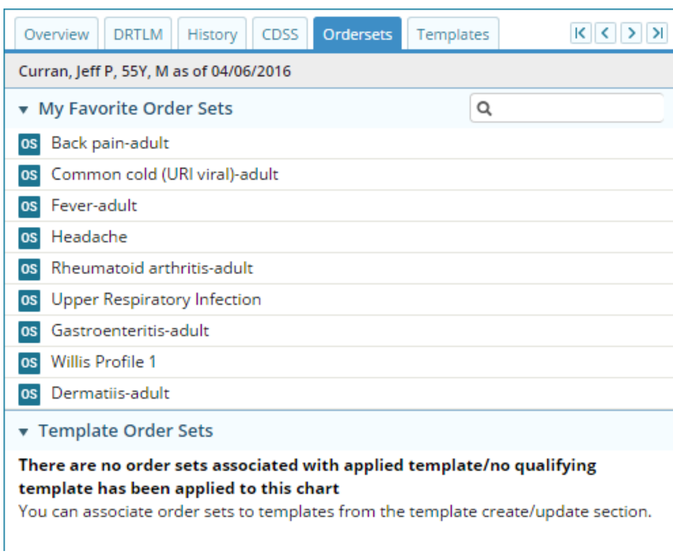


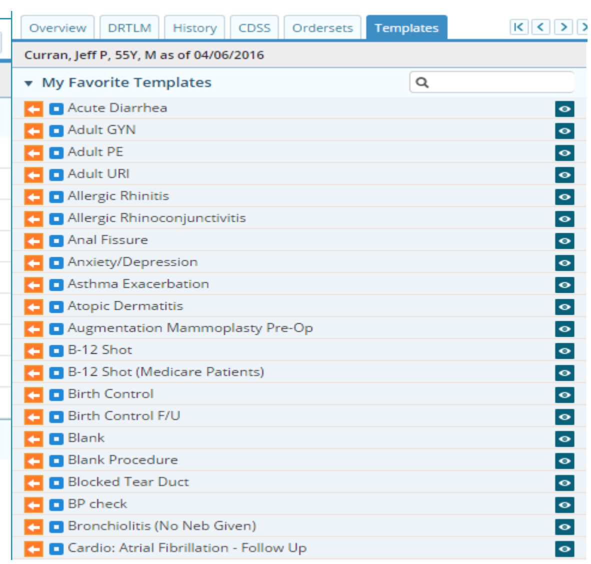
On the ICW, the selected tabs and options display:




Overview
DRTLM
History
CDSS
Ordersets
Templates
Curran, Jeff P, 55Y, M as of 04/06/2016
Medical History
Detached Retina-right eye
cataracts. Detached Retina-right eye
cataracts
Abdominal pain
abnormal CT chest
abnormal liver tests
abscess
Surgical History
cataract removal 2007
cataract-lens implants 2007
heart catheterization 1990
adenoidectomy
amputation, AKA
amputation, foot partial
appendectomy 1965
Family History
Father: deceased, heart attack, high cholesterol
Daughter(s): alive 24 yrs, healthy
Spouse: alive 40 yrs, healthy
Mother: alive 80 yrs, heart attack, high cholesterol, high blood pressure
Social History
Diet: controlled
Alcohol Screening: Points: 0, Interpretation: Negative
Alcohol: yes
Caffeine: no
Exercise: yes
Home smoke detector use: yes
Marital Status: single
New since last visit: none
Occup. exposure: none
Occupation: unemployed
Others at home no


Overview
DRTLM
History
CDSS
Ordersets
Templates
Curran, Jeff P, 55Y, M as of 04/06/2016
You are the primary care giver for this patient
CDSS Alerts
BP control in DM (130/80)
Depression screening
Pneumococcal vaccine
Sexual history taken
Practice Created Alerts
[G]colonoscopy 04/06/2016
[G]PSA,TOTAL 04/06/2016
[Dx]diabetes (HEMOGLOBIN A1C) 04/16/2009
Registry Alerts


Overview
DRTLM
History
CDSS
Ordersets
Templates
Curran, Jeff P, 55Y, M as of 04/06/2016
My Favorite Order Sets
Back pain-adult
Common cold (URI viral)-adult
Fever-adult
Headache
Rheumatoid arthritis-adult
Upper Respiratory Infection
Gastroenteritis-adult
Willis Profile 1
Dermatiis-adult
Template Order Sets
There are no order sets associated with applied template/no qualifying template has been applied to this chart
You can associate order sets to templates from the template create/update section.


Overview
DRTLM
History
CDSS
Ordersets
Templates
Curran, Jeff P, 55Y, M as of 04/06/2016
My Favorite Templates
Acute Diarrhea
Adult GYN
Adult PE
Adult URI
Allergic Rhinitis
Allergic Rhinoconjunctivitis
Anal Fissure
Anxiety/Depression
Asthma Exacerbation
Atopic Dermatitis
Augmentation Mammoplasty Pre-Op
B-12 Shot
B-12 Shot (Medicare Patients)
Birth Control
Birth Control F/U
Blank
Blank Procedure
Blocked Tear Duct
BP check
Bronchiolitis (No Neb Given)
Cardio: Atrial Fibrillation - Follow Up

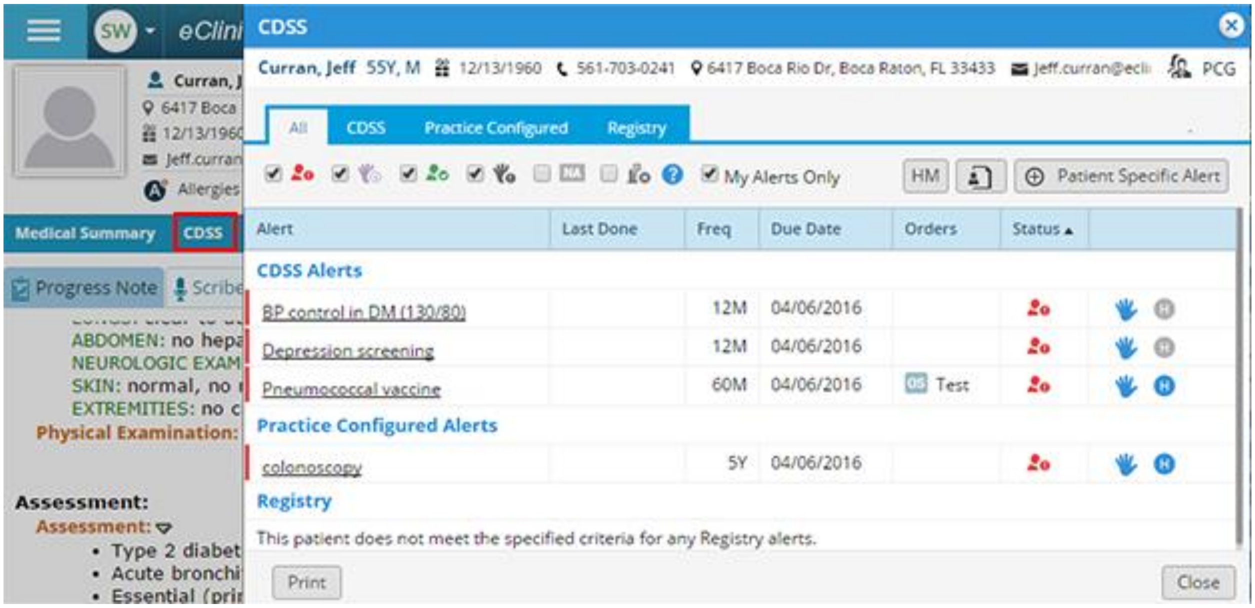
CDSS Measures

Path: *Progress Notes > Patient Dashboard > CDSS link*

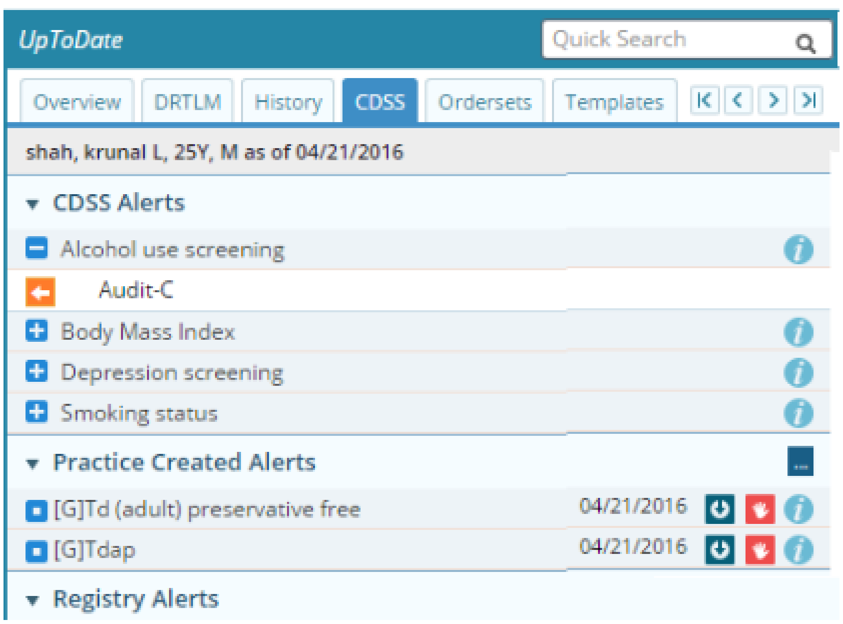
Monitor all the CDSS alerts set for a patient in the CDSS window.

To access CDSS alerts:

From the CDSS window, select the *All* tab to view all patient alerts, or select the *CDSS* tab to view only CDSS alerts:



The CDSS alerts also display in the ICW:



Features of ICW CDSS tab:

- All non-compliant CDSS alerts display in this section (*i.e.*, alerts that did not satisfy the numerator or denominator criteria).
- A plus icon displays next to an alert that is linked to an Order Set. Click the plus icon to view the associated alert.
- To apply the Order Set to the patient's Progress Notes, click the OS icons next to the alert.
- An arrow next to the alert displays indicates an associated quick order set. Click the arrow next to the order set to apply it to the Progress Notes, update a status for the order.

Alerts

Patient Specific Alerts

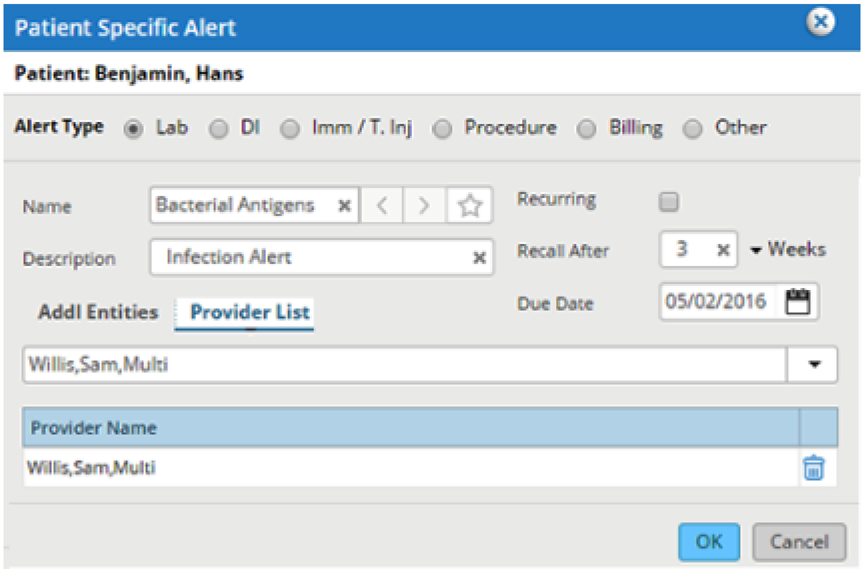
Path: Progress Note Patient dashboard > CDSS > Practice Configured

A practice can add clinical reminders to any of their patient's profile based on the alerts types.

To create patient specific alert:

1. Click the Patient Specific Alert button.

   The Patient Specific Alert window opens.
2. Select the Alert Type radio button.
3. In the Name text box, search for the alert.
4. In the Description box, briefly describe the alert.
5. (Optional) Enter the *Recall After* and *Due Date*:



6. Click *OK*.

> **Note:** Use the Error! Reference source not found. feature to recall Patient Specific, a nd Generic alerts.

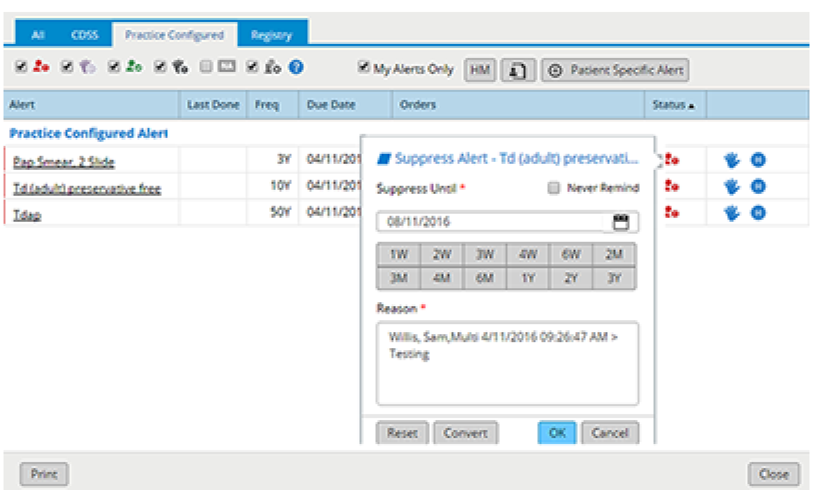
Suppressing Patient and Generic Alerts

Path: *Progress Note Patient dashboard > CDSS > Practice Configured*

To suppress the patient and generic alerts:

1. Click the suppress icon, next to the name of the alert.
2. Specify the duration to suppress.
3. OR

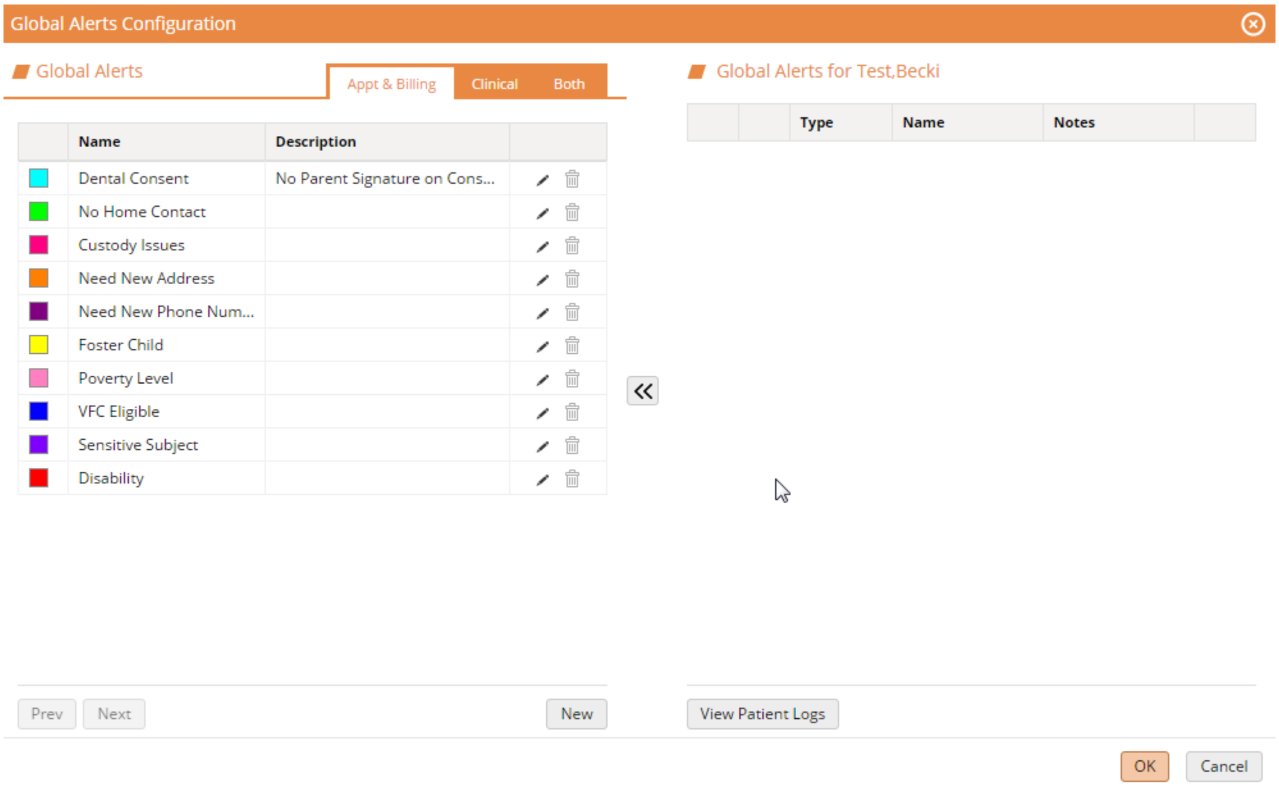
   Permanently suppress by checking the Never Remind box:



4. Click *Close*.

Global Alerts

Global Alerts are established to alert staff members of important information related to the patient. Global alerts allow staff members to see this information quickly and in several areas within the system.



These alerts will pop-up on the screen whenever the patient's appointment is created\modified on the Resource Schedule to alert the front desk staff. The associated colors of the global alert will show up in the patient look up screen and in the right chart panel. The Notes can also be customized with patient specific information associated with each Global alert.

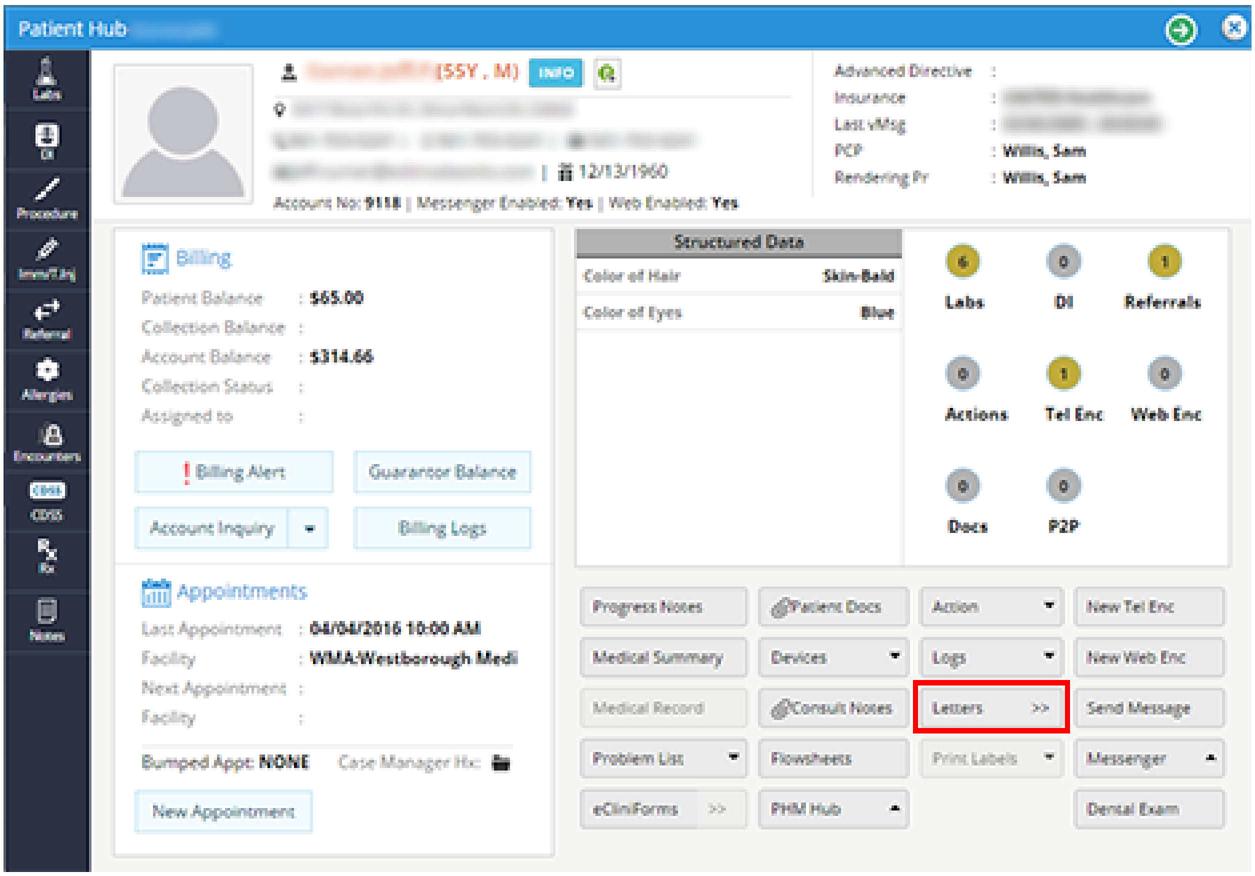
Generating and Printing Letters

Path: *Patient Lookup > Patient Hub*

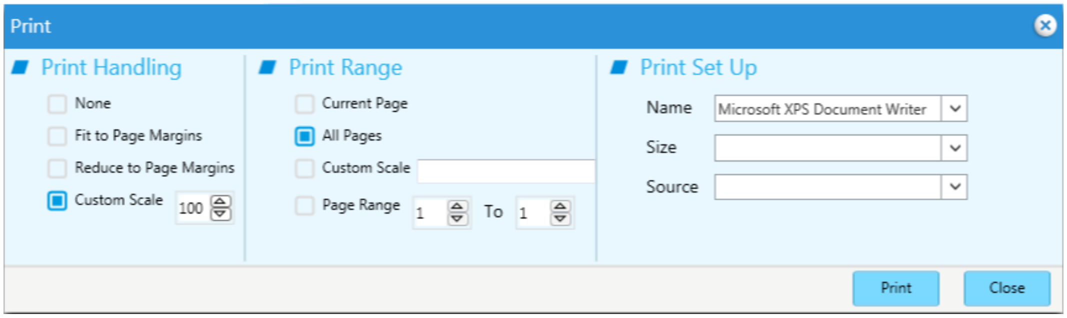
Letters can be accessed from the Patient Hub.

To generate or print letters from the Patient Hub:

1. From the Patient Hub, click *Letters*:



2. From the Letter Templates window, select the letter template and click the Run Letter icon.
3. After the letter is generated, print, publish to the Patient Portal, or save the letter using the icons at the bottom of the window.
4. In the Print window, select the printer and click *Print*:



Telephone Encounters

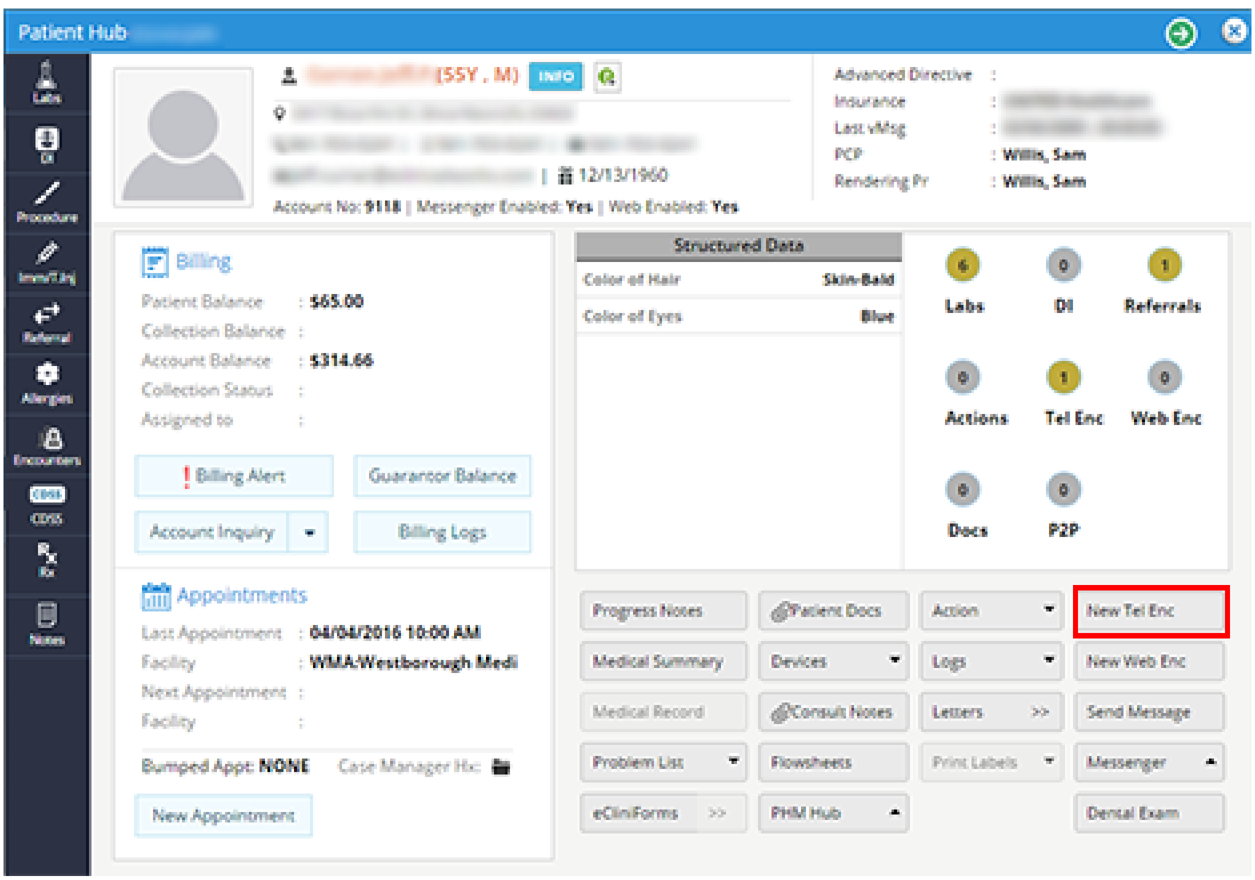
Creating New Telephone Encounters

Path: *Patient Lookup > Patient Hub*

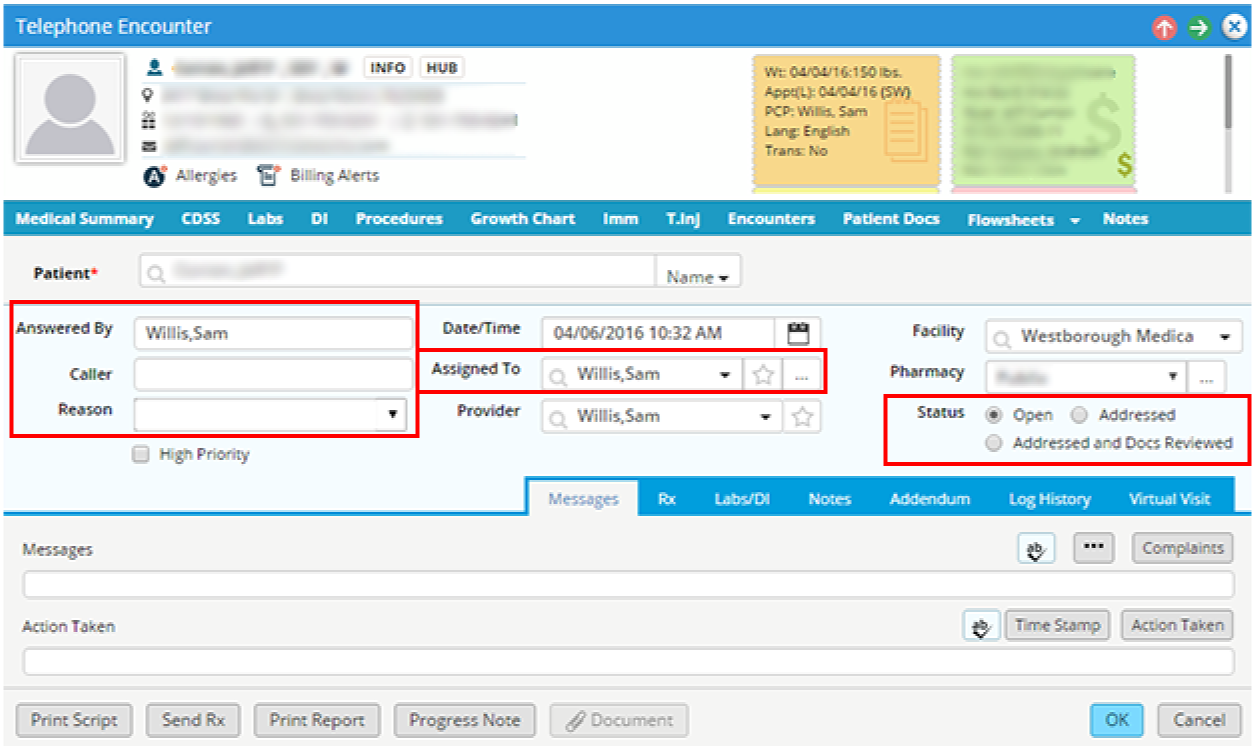
Create a new Telephone Encounter from the Patient Hub.

To create a new Telephone Encounter:

1. From the Patient Hub, click *New Tel Enc*:



2. From the Telephone Encounter window, enter the details for the encounter (*Caller, Reason, Message, Assigned To, etc.*):



The *Answered By* field populates with the user who created the Telephone Encounter, and the date and time are automatically populated.

a. Enter the name of the person who placed the call in the *Caller* field.

b. Document the reason for the call in the *Reason* field.

c. If this message requires immediate attention, check the *High Priority* box.

d. Document any additional message in the *Action Taken* field.

e. Select a staff member from the *Assigned To* field to assign the Telephone Encounter to a provider or another staff member.

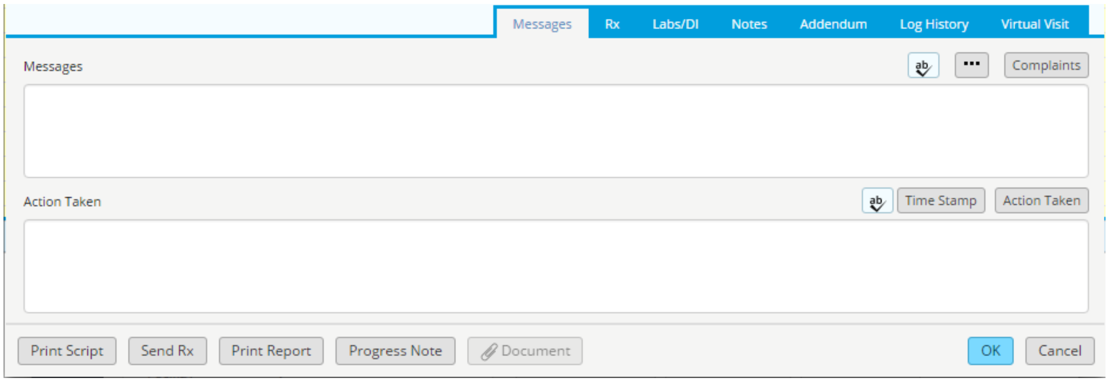
f. After the issue is addressed, change the Status of the Telephone Encounter from *Open* to *Addressed*.

3. Click *OK*.

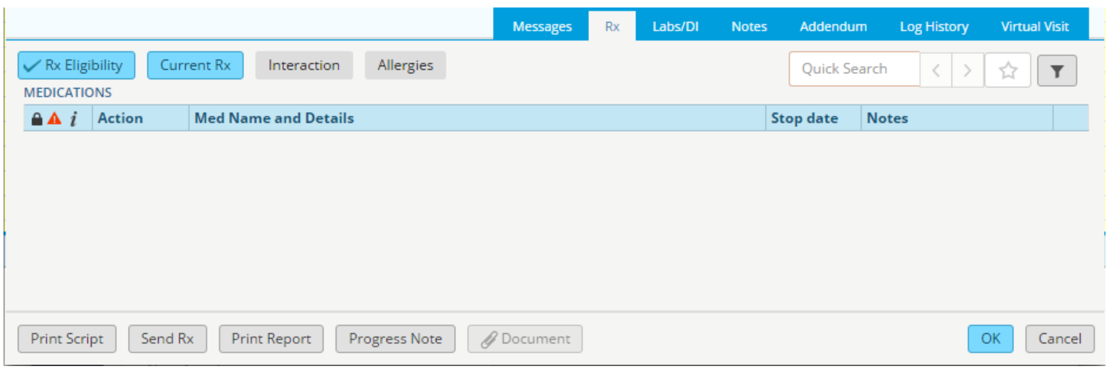
Telephone Encounters Tab Overview

The Telephone Encounters window contains the following tabs:

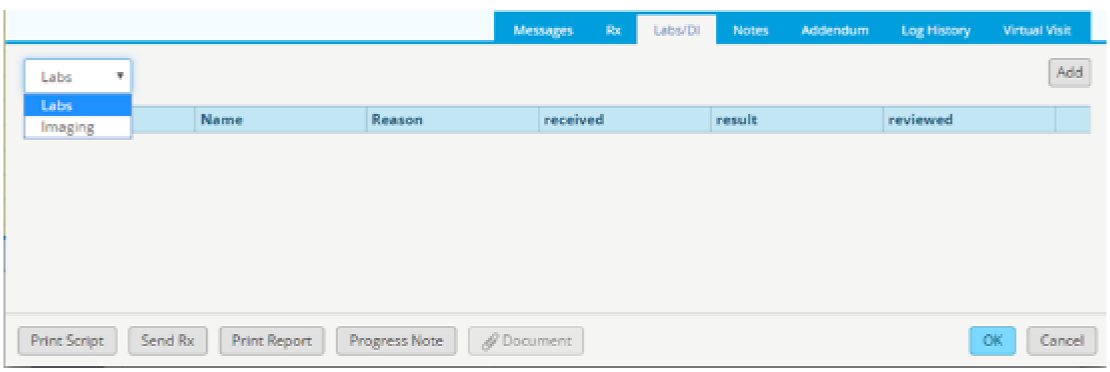
- **Messages**: document messages and actions taken:



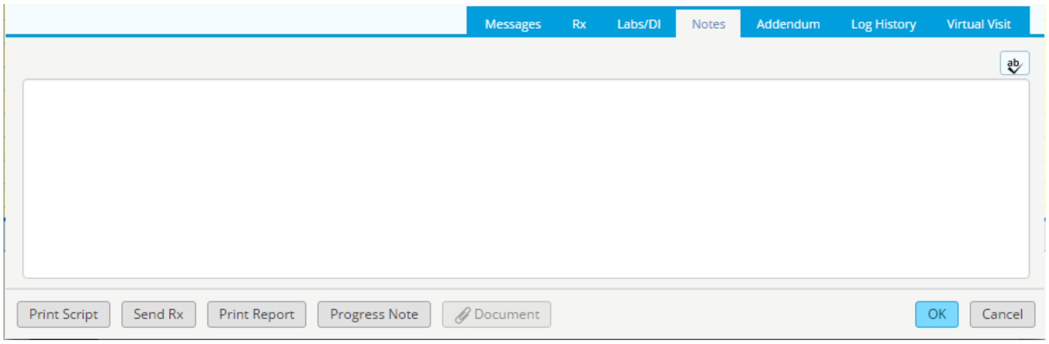
- **Rx**: refill or prescribe new medications when a patient doesn't have an appointment:



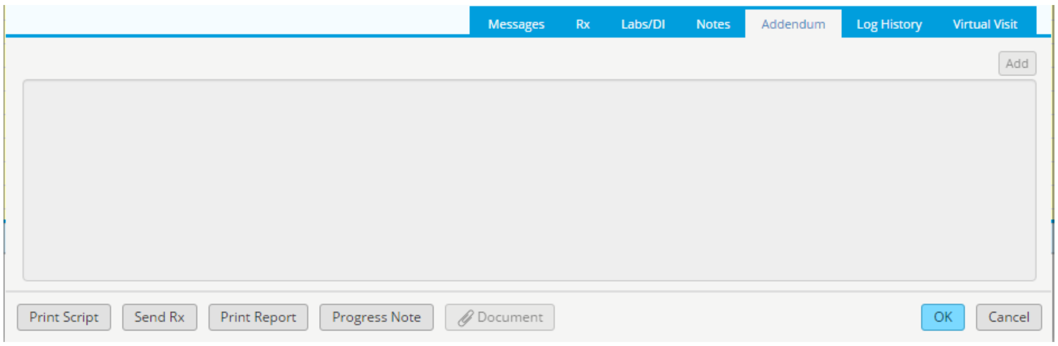
- **Labs/DI**: order tests for a patient when they are not at the practice:



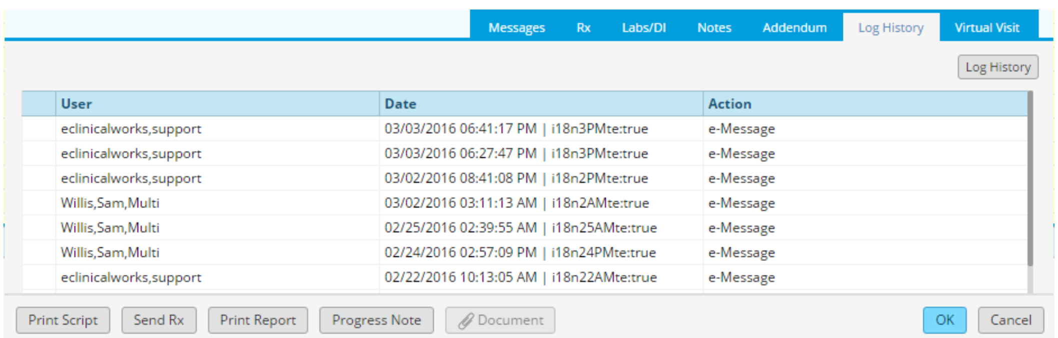
- **Notes:** document additional notes:



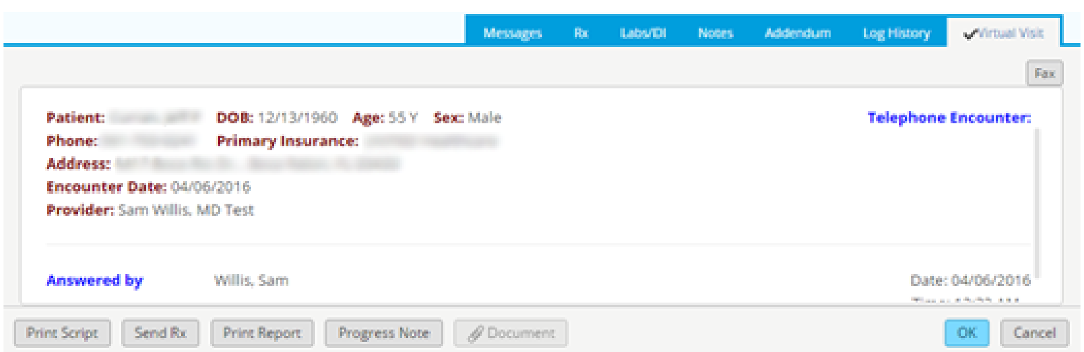
- **Addendum:** document notes after the Telephone Encounter has been marked as *Addressed*:



- **Log History:** display the access logs for this Telephone Encounter:



- **Virtual Visit:** access virtual Progress Notes:



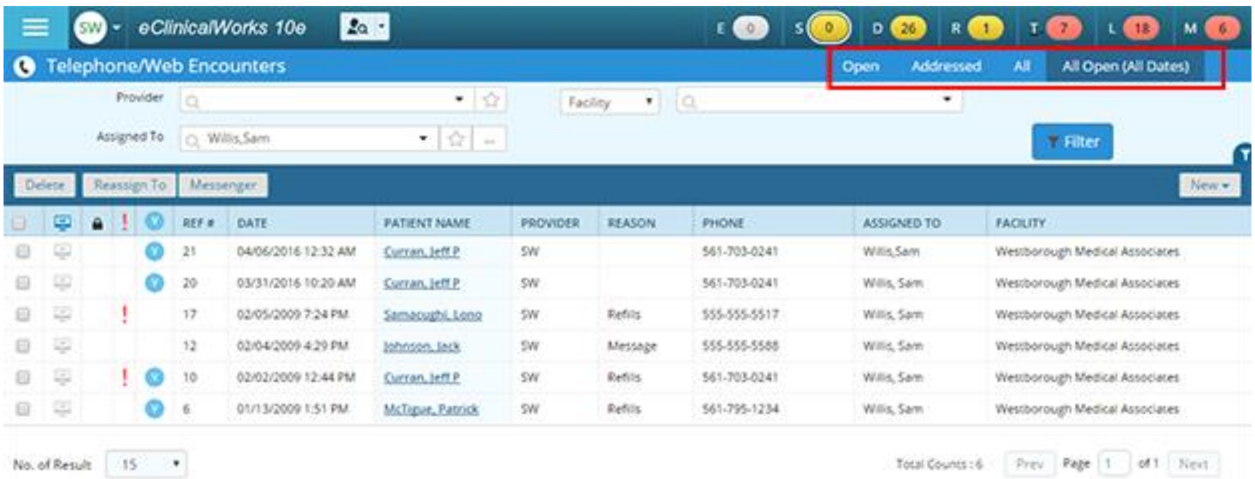
Looking Up Assigned Telephone Encounters

Path: *T Quick-Launch button*

Look up assigned Telephone Encounters by clicking the *T* Quick-Launch button. The number in the button indicates the number of Telephone Encounters, Web Encounters, and Actions that are assigned to the current user.

The *T* Quick-Launch button displays red to indicate that a *High-Priority* Telephone Encounter has been assigned to the user.

Active (Open) Telephone Encounters can be found under the Open, All, and All Open (All Dates) tabs:



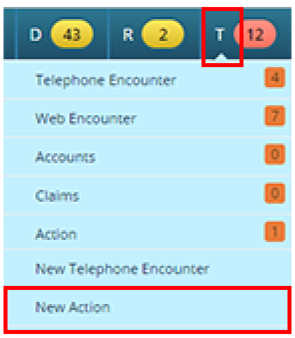
After the Telephone Encounter has been marked as *Addressed*, it displays in the *Addressed* tab.

Actions Overview

The Action feature enables users to create and assign tasks to themselves or other staff members in the system. Actions can be created by clicking *Action* from the Patient Hub, or by clicking *New Action* from the *T* Quick-Launch link.

Actions can be assigned to staff members with messages or certain attachments (*i.e.*, encounters, labs, documents, DI, Specialty Forms, and procedures). The status of the Action can be used to track the progress (*Not Started, In Progress, Completed, Overdue,* and *Canceled*). An Action can be configured to recur repeatedly over a specified period of time.

The number of actions assigned to a user display in the *T* Quick-Launch Link:



Creating a New Action

Path: *Patient Lookup icon > Patient Hub > Action button*

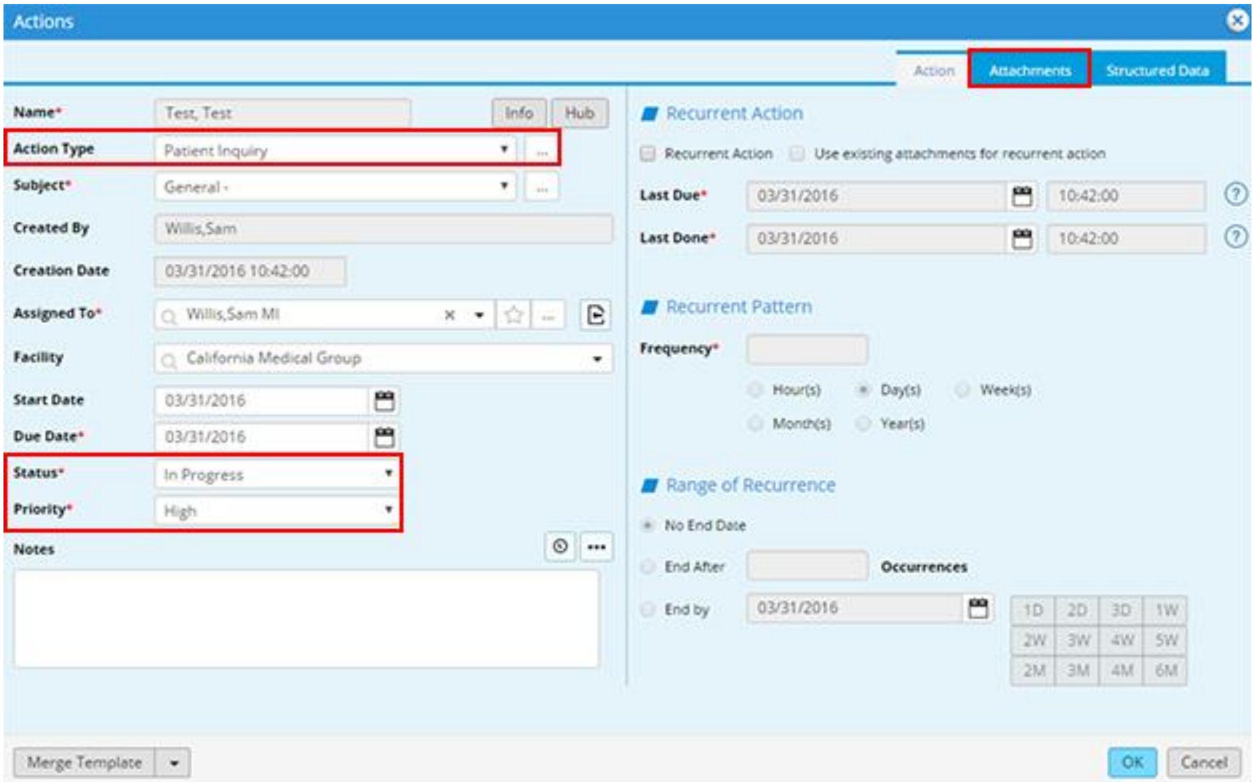
OR

T Quick-Launch link > New Action

To create a new action:

1. From the Action window, select the *Action Type* from the custom-built list.
2. Select the *Attachments* tab to include an attachment from Patient Documents with the Action.

3. Select the *Status* and *Priority* for this action:



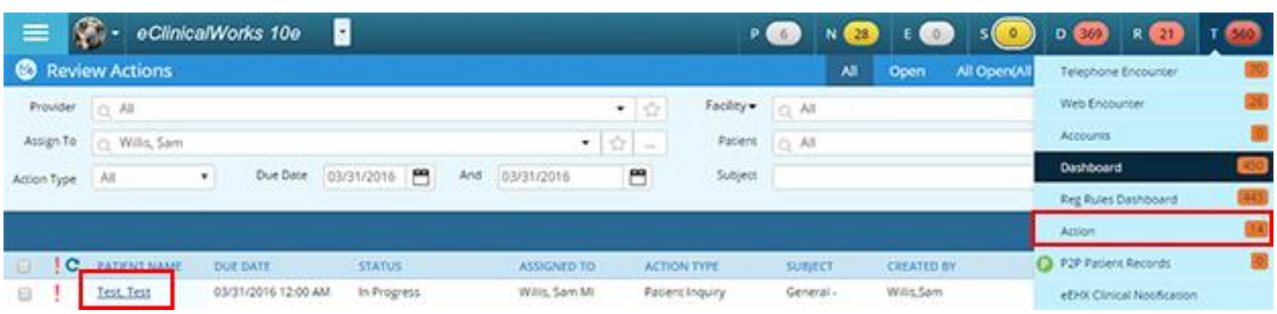
Working with Assigned Actions

Path: *T Quick-Launch link > Action*

Open and address assigned Actions from the T Quick-Launch link.

To open assigned Actions:

1. From the Review Actions window, click the patient name link for the action to open it:

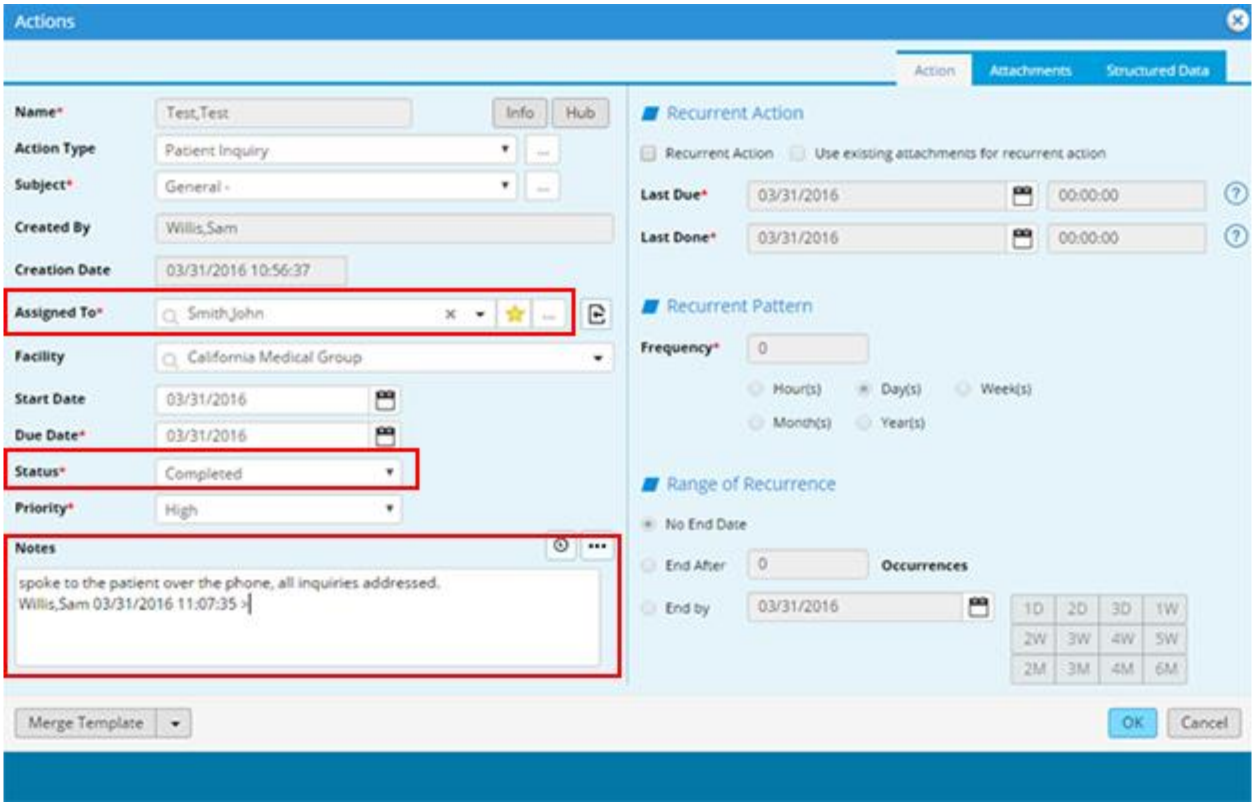


2. In the Actions window, review the information.
3. Document actions taken in the *Notes* field.

4. Assign the action to another user.

   OR

   Mark the Action as *Completed*:



Documents

Scanning Documents & Working with Scanned Documents

eClinicalWorks comes with a document management feature which allows:

- Staff to scan patient documents into the system and attach the documents to the electronic chart (consent forms, lab results, consult reports, etc.).
- External entities to fax documents directly into the EMR system. The document will be faxed electronically into the system and the staff will be able to attach the document to the patient's electronic chart.

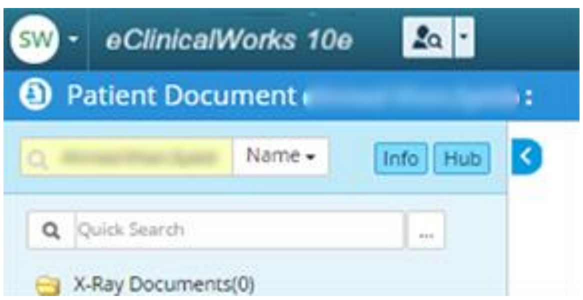
Path: *Main Menu > Documents icon > Patient Documents*

OR

Patient Lookup icon > Patient Hub > Patient Docs button

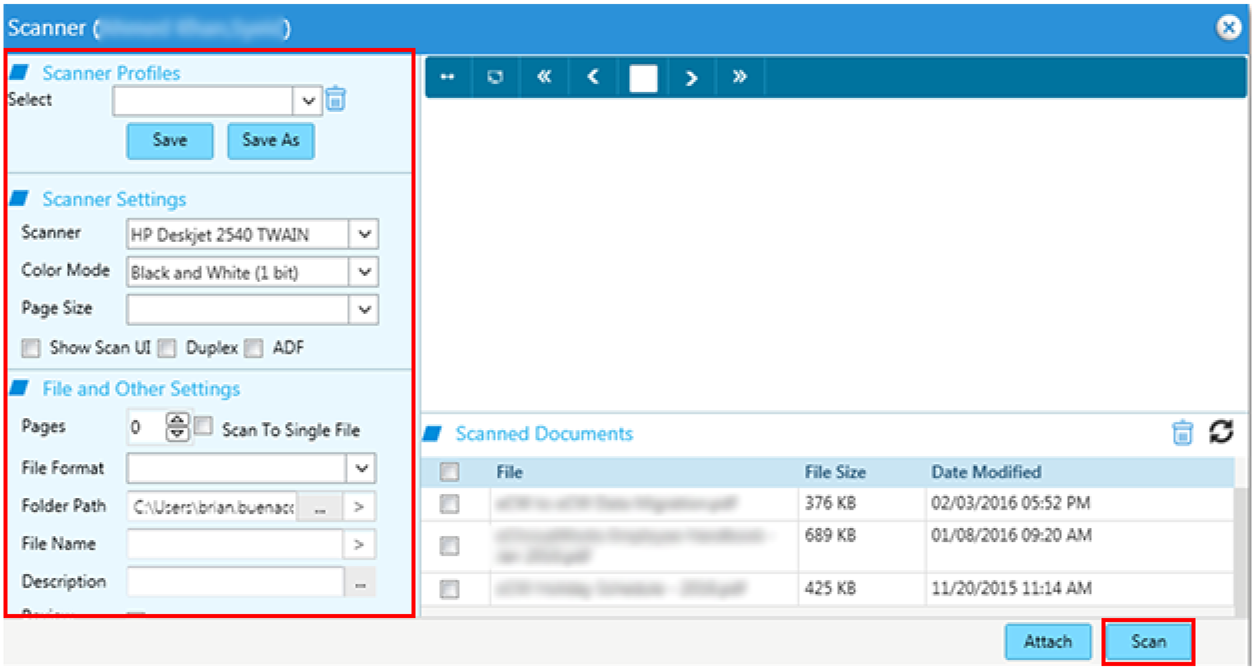
To scan a document and save it in Patient Documents:

1. In the Patient Documents window, search for and select the patient:



2. From the *Options* drop-down list, click *Scan*.

3. From the Scanner window, configure the scanner settings.
4. Feed the document into the scanner and click *Scan*:



The documents generate in the scan bucket. Scanned documents are temporarily stored in the Scanned Documents section of this window.

The following scanning options are available:

Option	Description
Scan Duplex	Enables users to scan both sides of the document.
Scan to Single File	Enables users to scan multiple documents (pages) into one electronic file.
Color Mode	Enables users to scan documents in black and white, grey scale, or color.
File Format	Enables users to scan documents in .tiff, .pdf, .jpg, or .png files.
Pages	Enables users to define the number of documents to be scanned.
DPI	Enables users to define the quality of the documents.
Show Scan UI	Enables users to display the scanner's user interface to configure additional settings.
ADF	Enables users to enable or disable the Automatic Document Feeder functionality.

Attaching a Scanned Document to the Patient's Chart

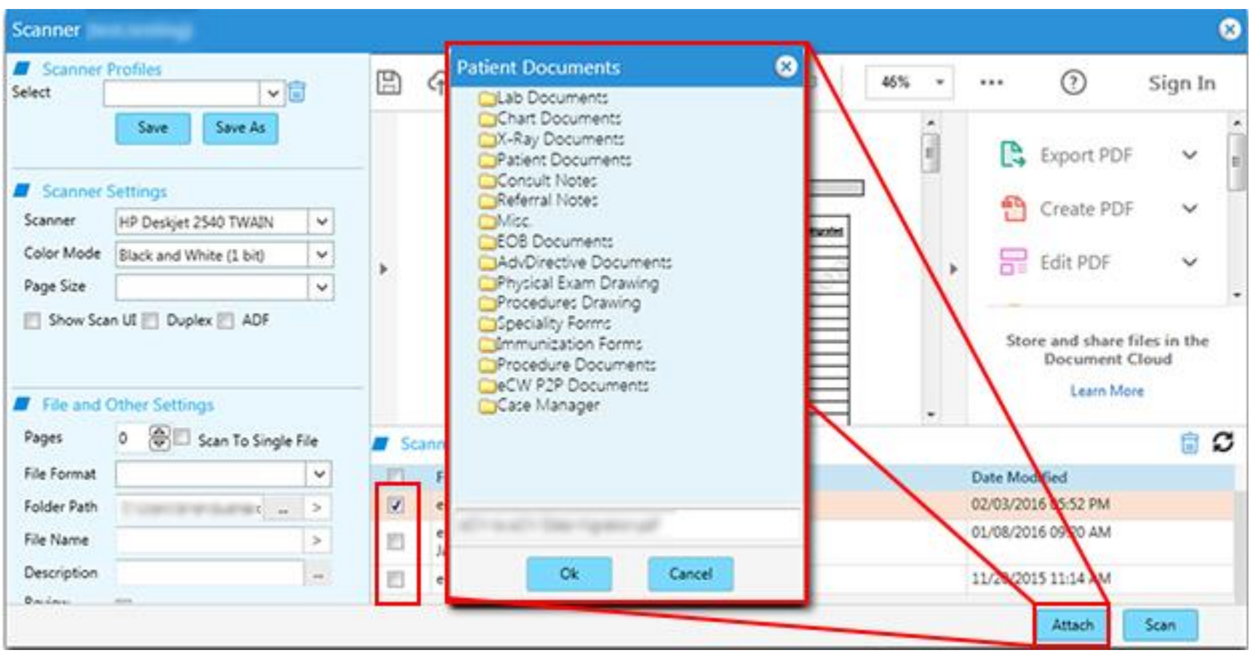
Path: *Main Menu > Documents icon > Patient Documents*

OR

Patient Lookup icon > Patient Hub > Patient Docs button

To attach a scanned document to the patient chart:

1. In the Patient Documents window, search for and select the patient.
2. From the *Options* drop-down list, click *Scan*.
3. From the Scanner window, scan the document.
4. In the Scanned Documents section, ensure that the file name has been documented for the scanned document.
5. Check the box next to the document, and click *Attach*.
6. In the Patient Documents window, select the folder to move this document and click *OK*:

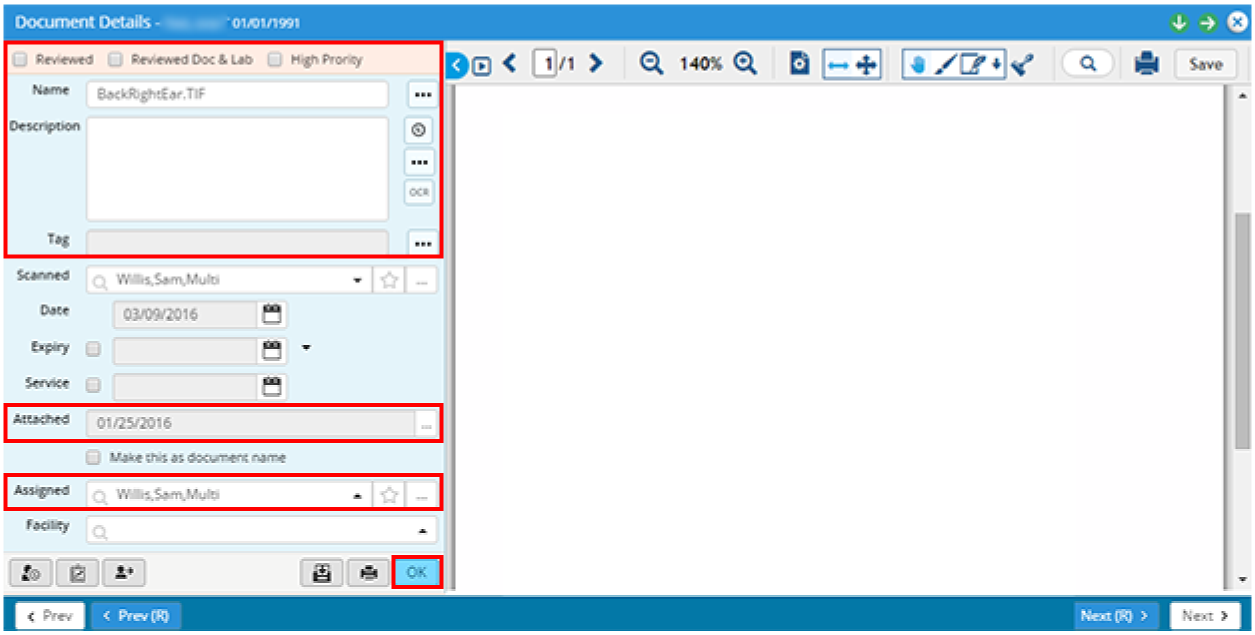


7. From the Document Details window, enter a *Name* and *Description* for the document.
8. (*Optional*) *Attach* the document to a lab or DI order.
9. (*Optional*) Add a document *Tag*.
10. (*Optional*) Select one of the review options:
    - **Reviewed** – check if a sign-off is not required.
    - **Reviewed Doc and Lab** – check if a sign-off is not required and the lab has been reviewed.

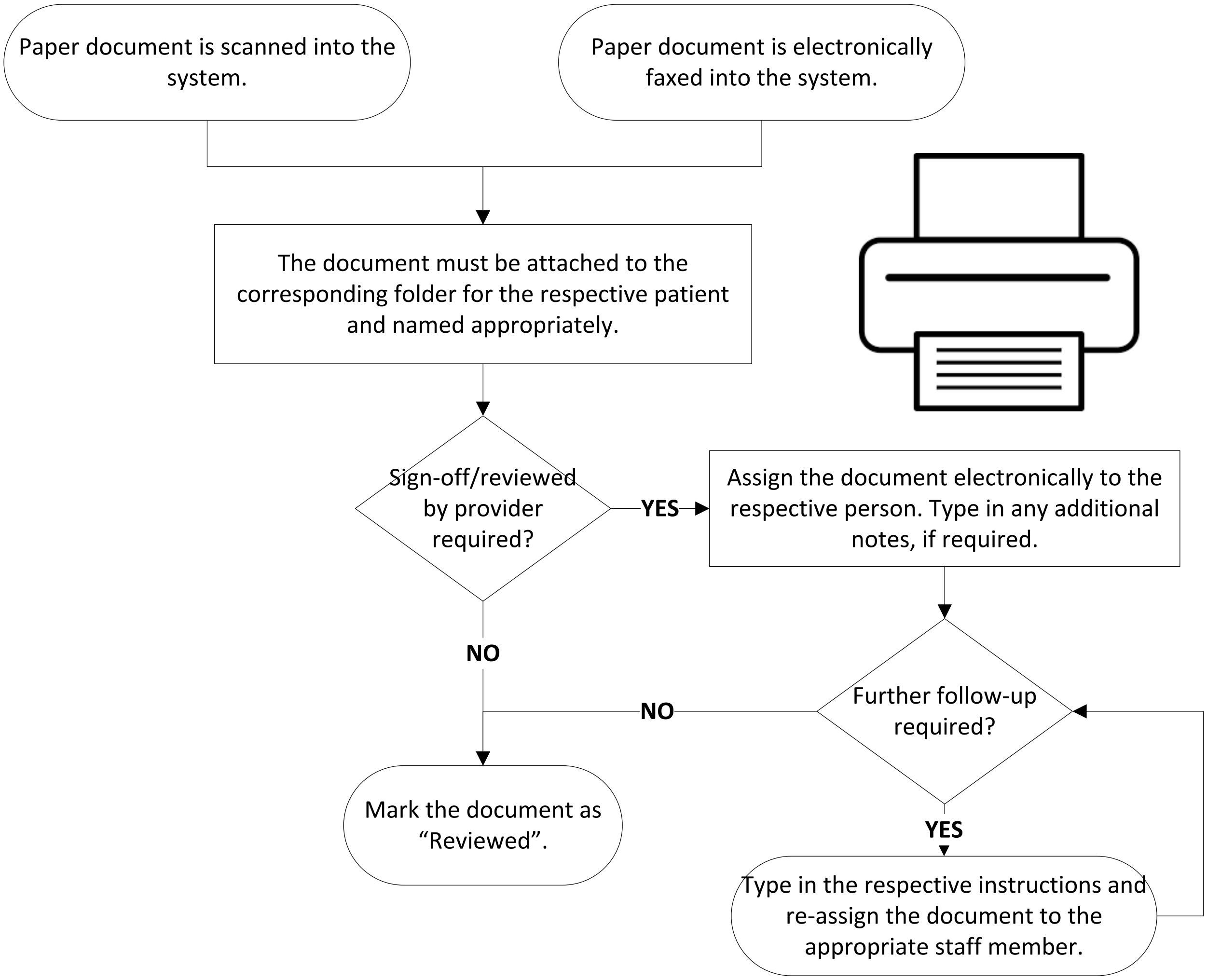
- **High Priority** – check if the document is high-priority; when this document is assigned to another user, their D Quick-Launch button will display red.

11.(*Optional*) Assign the document to another user.

12.Click *OK*:



The below workflow illustrates the management of documents that are scanned into the system and that are faxed into the system.



Receiving Lab and DI Results

Path: *Documents > Review Documents*

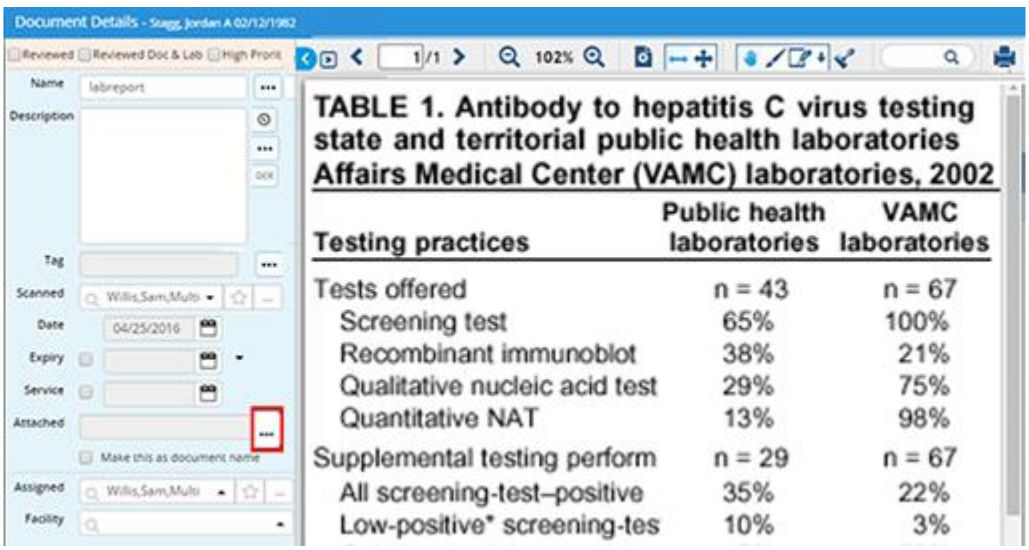
Results of labs and diagnostic imaging may be received in print or by fax. Printed reports have to be scanned to our system. Faxed reports are stored in the Fax Inbox. Transfer the reports to the appropriate folders of the Patient Documents and link it to the corresponding lab or diagnostic imaging order.

To link lab reports to patient documents:

1. From the Review Documents window, click the name of the patient.

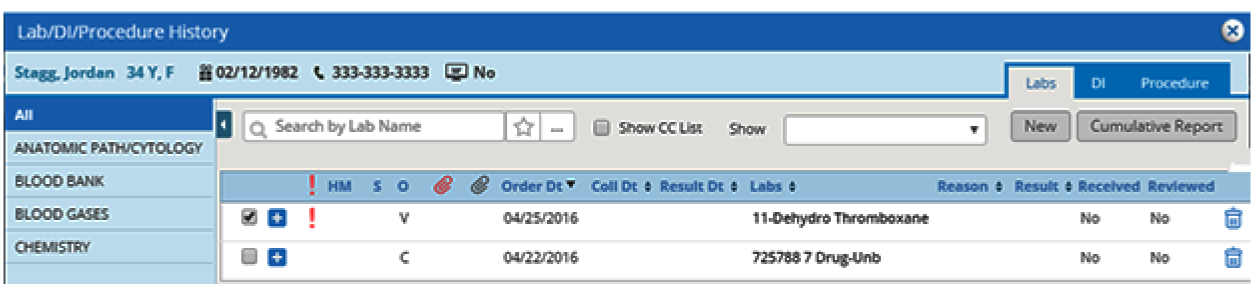
   The Document Details window opens.

2. Click the Attached *More (…)* button.:



   The Lab/DI/Procedure History window opens.

3. Check the box next to the report:

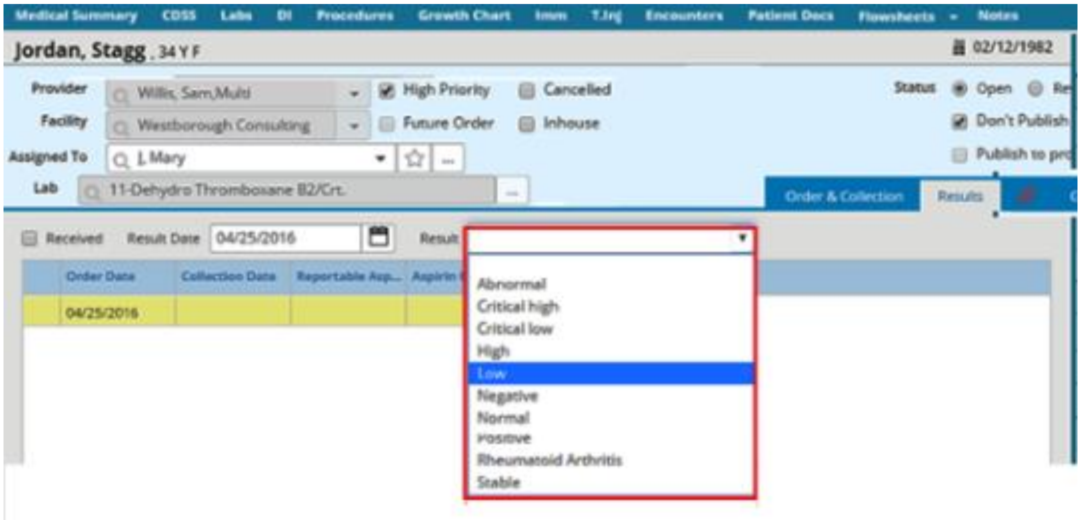


4. To enter the results, click the name of the lab.

   The Lab Results window opens.

5. Click *Results*.

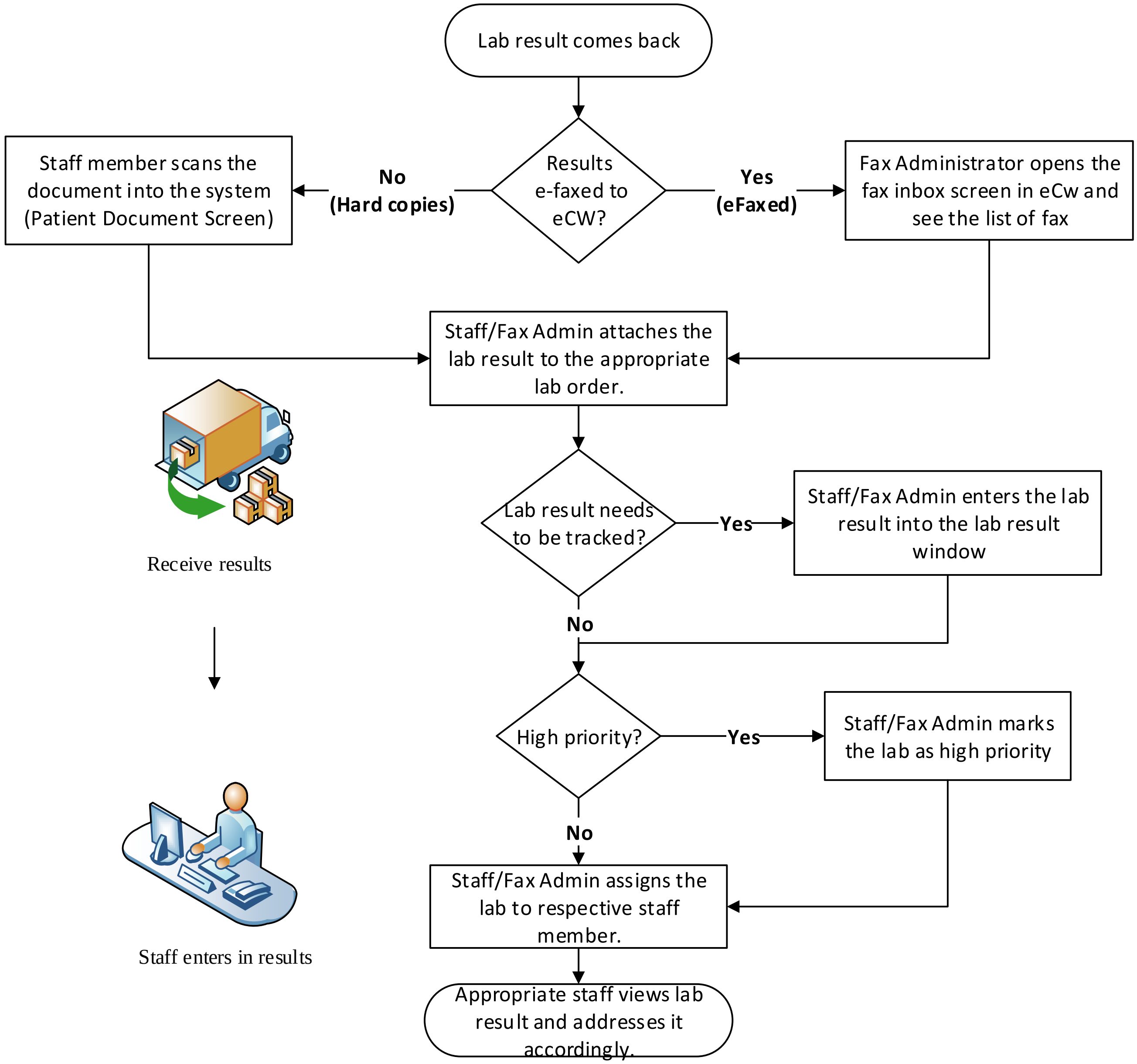
6. From the *Results* drop-down list, select the description for the result:



7. (*Optional*) To display with an exclamation mark for urgent attention, check the High Priority box.
8. Time stamp after entering any description notes.
9. Click the Assigned To *More (...)* button.
10. Select the name of the provider.

    The provider can access the report in the *D* Quick-Launch button.
11. After reviewing the report, check the *Reviewed Doc & Lab* box.

The below workflow illustrates when the practice receives results from labs and diagnostic imaging.



Receive results

Staff enters in results

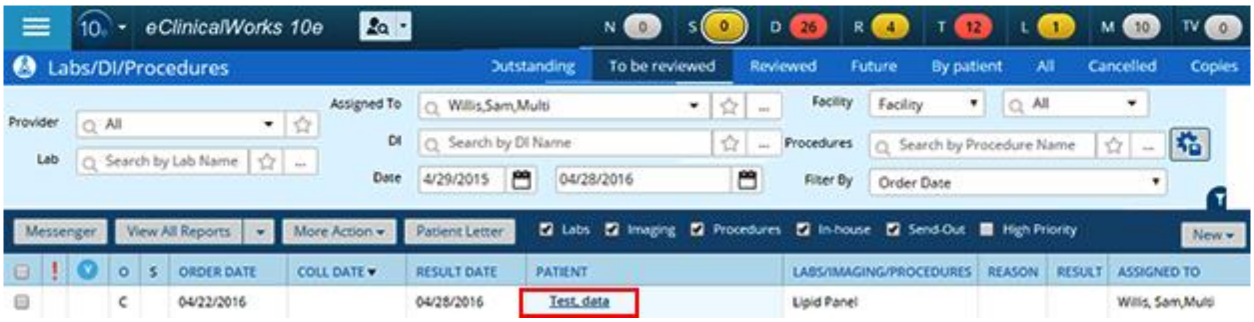
Receiving Electronic Lab Results

Path: *L Quick-Launch button > To be reviewed tab*

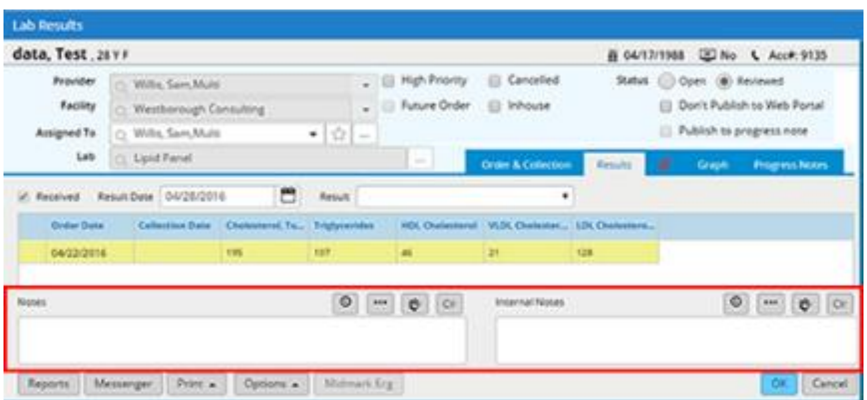
A practice after going live with the lab interface, can receive reports from a lab company or another hospital electronically to eClinicalWorks. Providers receive the electronic lab results to their *L* quick launch button.

To review and update lab results:

1. Search for and click the name of a patient:

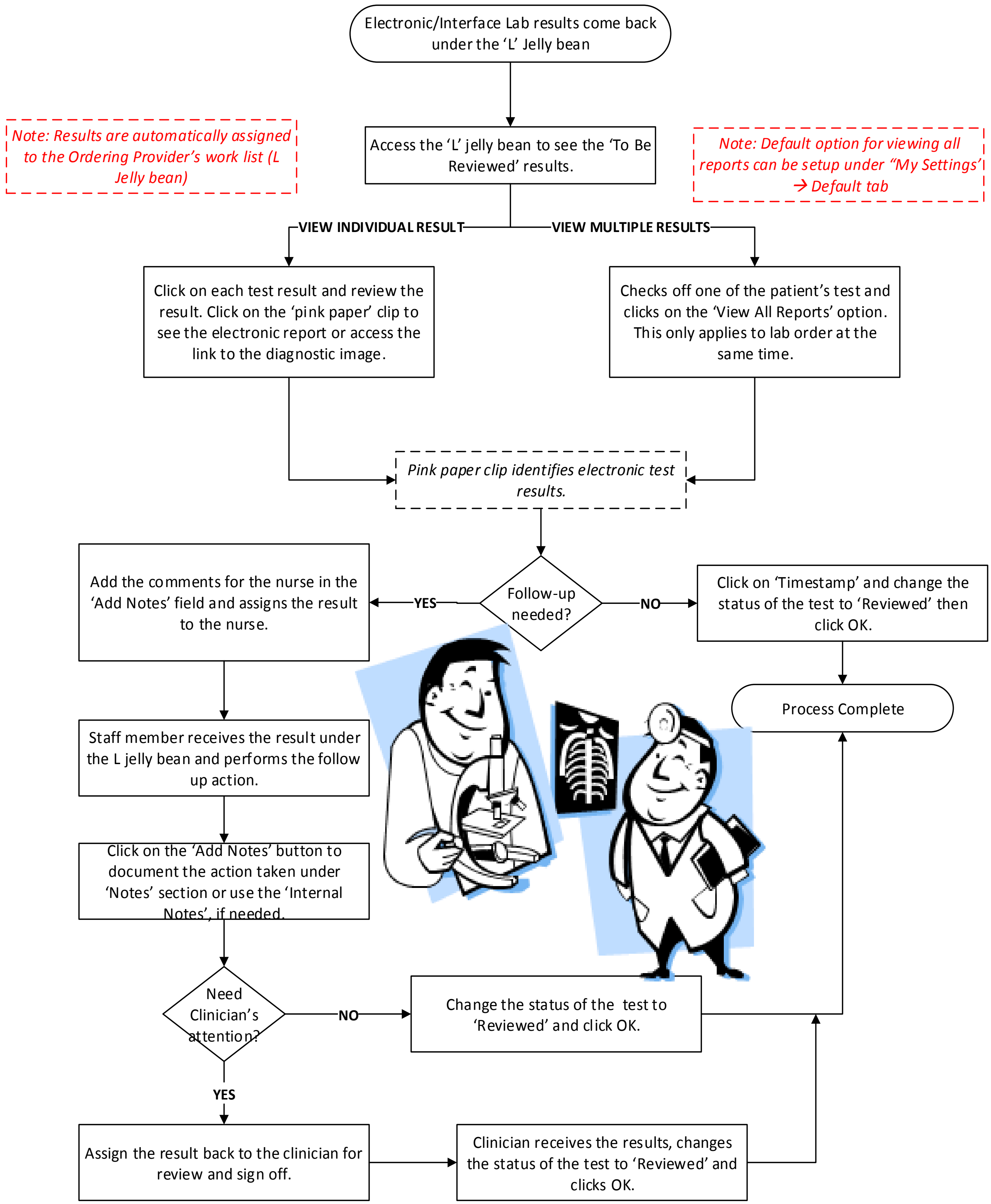


2. To view the lab attributes, click *Results*.
3. To open actual report (received from the lab company, or hospital), click the pink paper clip.
4. In the *Notes* section, add any additional comments:



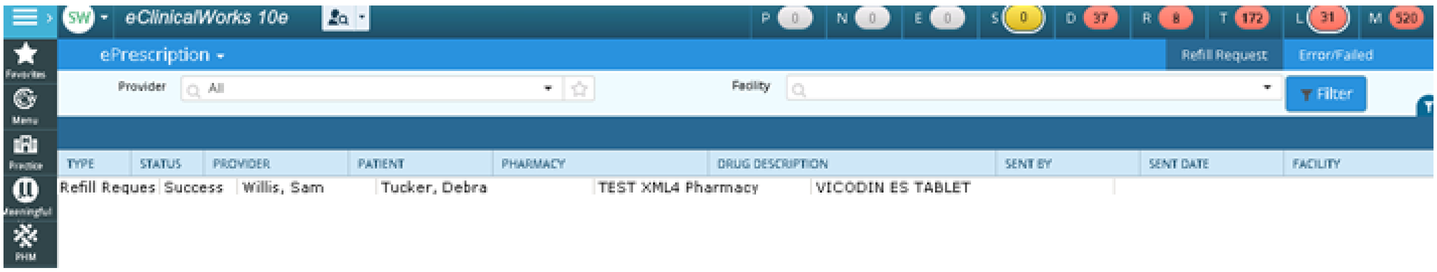
5. On completing the review, check the *Reviewed* radio button.

The below workflow illustrates the lab/DI process with a bi-directional interface.

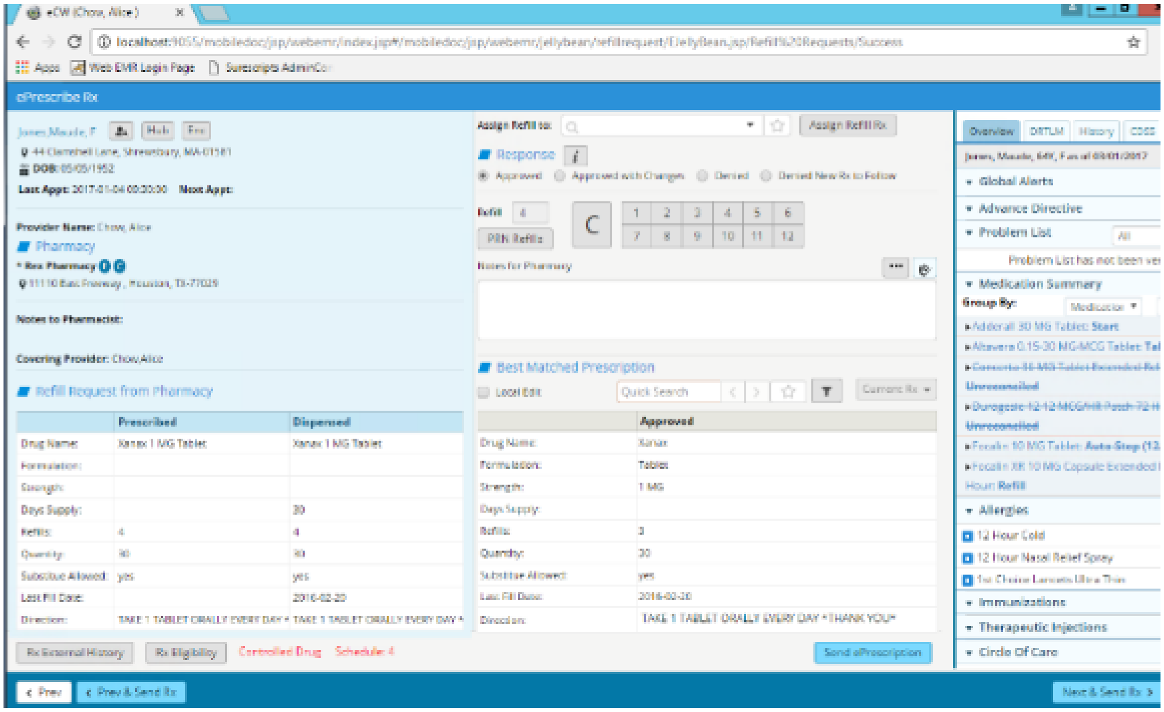


Receiving Electronic Rx Refill Requests

In addition to sending the Rx refill request via fax and telephone messages, Pharmacies can send the electronic refill request directly into eClinicalWorks. Once received, the 'E' jellybean of the provider will increase. The provider can respond to the eRequest by:



1. Click on the 'E' Jellybean.
2. Select the refill request (double click).
3. From the ePrescribe Rx Window, select the action you would like to take:
   a. Select 'Approved' to approve the refill request.
   b. Select 'Denied' to deny the refill request.
   c. Select 'Approved with Changes' to indicate that the request is approved with specified changes.
   d. Select 'Denied New Rx to Follow' to indicate that the request is denied and that a new drug will be prescribed.
   e. Select 'Approved with Changes' if making changes to refill prescription before approving it.



4. If you approved or denied the refill request, provide details for the refill in the 'Refill Details' pane:
   - Click the number buttons to specify the number of refills allowed or enter the number in the field.
   - Click the 'C' button to clear the field.
   - Enter notes in free text to accompany the response in the Notes field.
   - Enter notes to accompany the denial in the Notes field.
5. The 'Best Matched Prescription' pane displays the details of the drug in the local database that is the best match for the drug that was originally prescribed. If this drug is not in the local database, this information appears in red and select the best match:
   - Click 'Select Rx' to search for and select the best match from the local database.
   - Click 'Cur Rx' to view the patient's current prescriptions and select the best match from that list.
6. Click 'Send ePrescription' to send the refill.

Managing Electronic Refill (E Quick-Launch Button)

Incoming medication refill request.

Nurse accesses the E Jellybean and sets the filters to view refill requests for providers.

Double click on each of the requests and based on the refill protocol, respond to the request appropriately.

Can the request be fulfilled by the nurse ?

YES

On the ePrescription Rx screen, select the appropriate 'Response'; approved, approved with changes, denied or denied new rx to follow and enter the 'Refill Details'.

Select the 'Best Matched Prescription' if information appears in red. Click 'Send ePrescription' button to send the refill to the patient's pharmacy.

Process Complete

Note: The 'Best Matched Prescription' pane displays the details of the drug in the local database that is the best match for the drug that was originally prescribed. If this drug is not in the local database, this information appears in red and you must select the best match.

- Click 'Cur Rx' to view the patient's current prescriptions and select the best match from that list.
- Click 'Select Rx' to select the best match from the local database.

NO

Select the 'Denied' response and select the appropriate denied reason from the drop-down list.

Click 'Send ePrescription' and confirm the action to create a Telephone Encounter.

On the telephone encounter, select the appropriate refill provider and enter the refill details under the 'Message' tab for the provider.

Click on the 'Add' button to add the appropriate action taken detail, forward the message to the provider (changing the 'Assigned To' field) and click OK.

Provider receives the telephone encounter, reviews the refill request, responds appropriately and documents the action taken on the telephone encounter.

Note: New prescriptions can be selected and sent under the 'Rx' tab.

Follow up action by nurse required?

YES

Provider assigns the telephone encounter to the nurse.

Nurse performs required task, timestamps and documents action taken on the telephone encounter.

Nurse addresses the telephone encounter

NO

Provider addresses the telephone encounter

Electronic Faxing

Incoming Faxes

Path: *Main Menu > Documents icon > Fax Inbox*

OR

D Quick-Launch link > Fax Inbox

eClinicalWorks comes with document management feature which allows external entities to fax the document directly into eClinicalWorks. The document then can be attached to the patient's electronic chart.

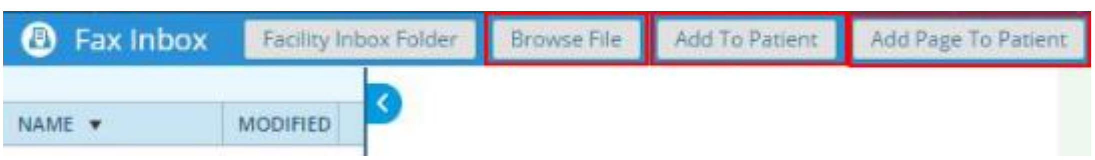
Prior to receiving the faxed document, the practice administrator maps the eClinicalWorks application to the fax inbox for each facility by typing the fax inbox folder's location on the *Fax Server* window. The *Fax Server* window is accessed from the *Fax Server* tab in the *eCW Menu*.

To attach received faxes to the respective patients:

1. Click the *Browse File* button to add a faxed document.
2. In the Browse window select the document, and click *Open*.
3. In the Fax Inbox, select the document and click the *Add To Patient* button.

   OR

   To add the individual pages from the received fax, click the *Add Pages To Patient* button:



Assigning a Faxed Document to a Staff Member

Path: *Main Menu > Documents icon > Fax Inbox*

To assign a fax document to someone within the practice:

1. Select the document.
2. Right-click the document and click the *Send To* option.
3. Select the appropriate provider or staff member.
4. Click *OK*.

Note: Checking the *Delete document from inbox* box deletes the document form the Fax Inbox, not the patient record.

The provider or staff member will receive the document in the D Quick-Launch button.

Creating Telephone Encounters from Faxed Documents

Path: *Main Menu > Documents icon > Fax Inbox*

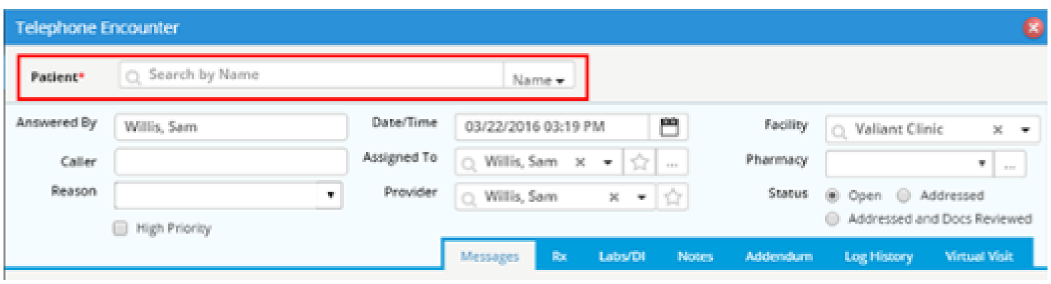
OR

D Quick-Launch link > Fax Inbox

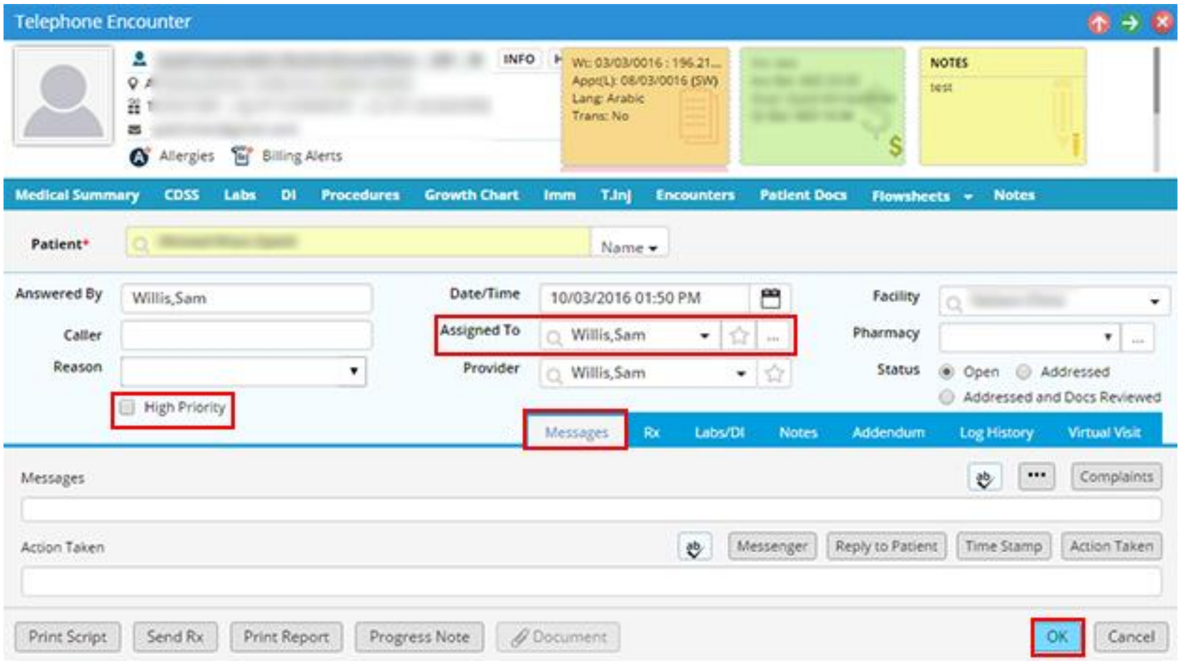
If a refill request is faxed to the practice, create a Telephone Encounter to communicate this request to the provider.

To create a Telephone Encounter from a faxed document:

1. From the Fax Inbox window, click the arrow icon next to the document, and click *Create Telephone Encounter* from the drop-down list:
2. From the Telephone Encounter window, search for and select the patient:



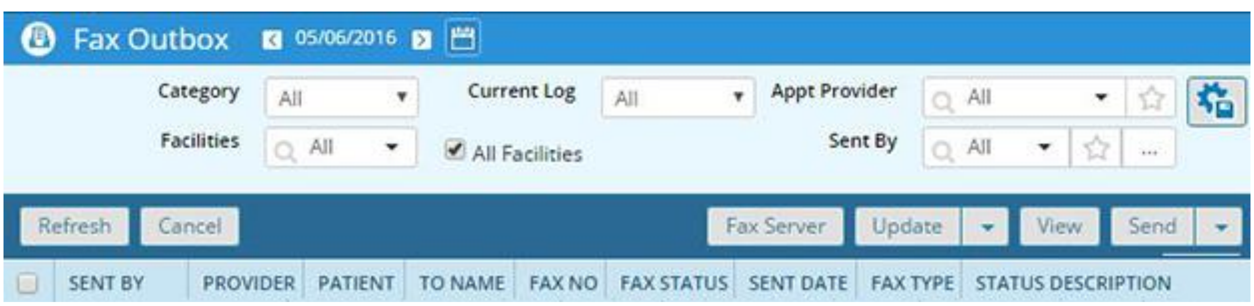
3. Complete the message in the *Messages* tab.
4. Assign the Telephone Encounter to the applicable provider or staff member.
5. (*Optional*) Check the *High Priority* box to indicate that this encounter requires immediate attention.
6. Click *OK*:



Outgoing Faxes

Path: *Main Menu > Documents icon > Fax Outbox*

eClinicalWorks allows users to electronically fax documents from the application. User can use the fax feature by clicking on the *Fax* button from various section of the application (Ex. Progress Notes, Patient Documents, Lab/DI Order, *etc*.). Once the document(s) is faxed out, the user can monitor the status of the (sent out) faxes through *Fax Outbox* window.

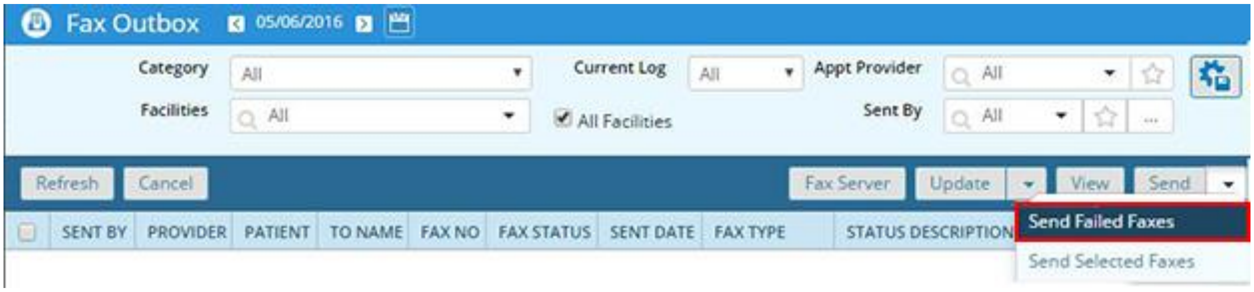


Resending Failed Faxes from the Fax Outbox

Path: *Main Menu > Documents icon > Fax Outbox*

To resend failed faxes:

In the Fax Outbox, from the *Send* drop-down list, select the *Send Failed Faxes* option:



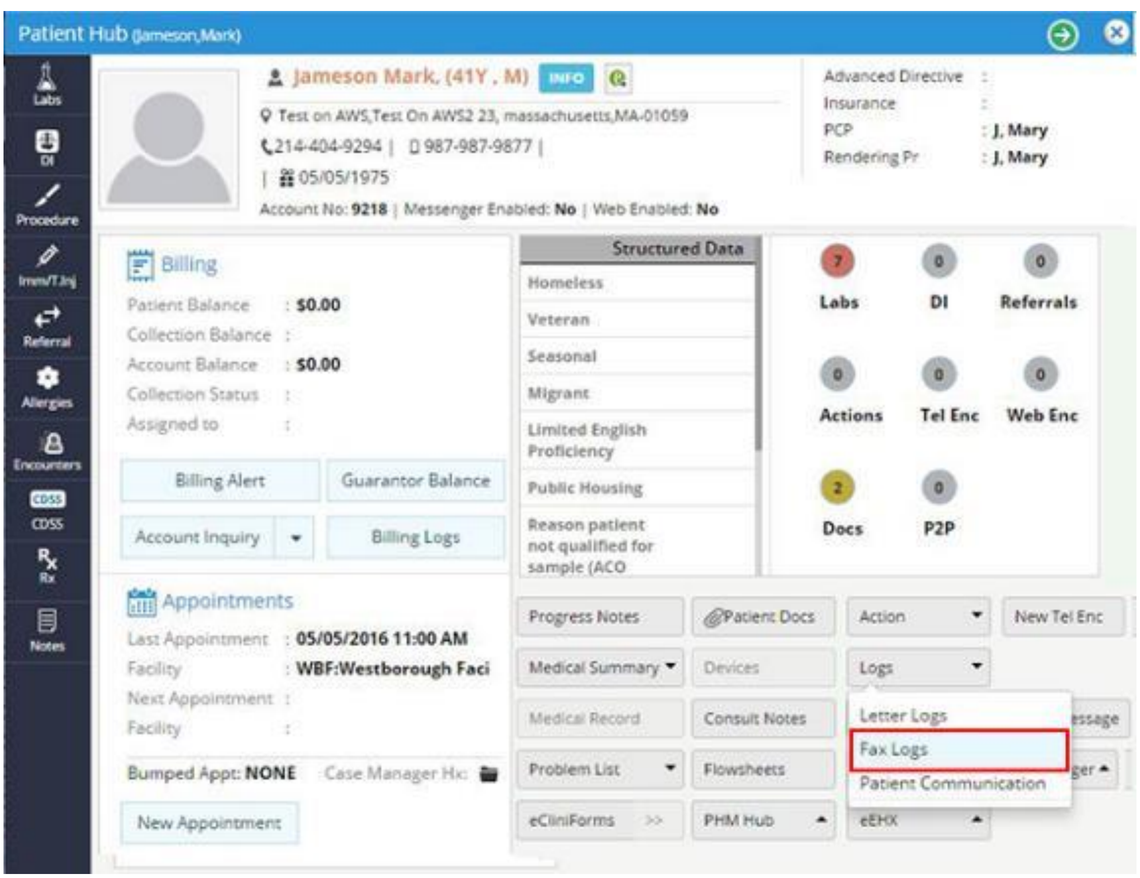
The fax server logs the request and begins transmitting the failed faxes.

Viewing Fax Logs in the Patient Hub

eClinicalWorks keeps a log of all faxes sent per patient.

To view fax logs in the patient Hub:

In the Patient Hub, from the Logs drop-down list, select the *Fax Logs* option:



Appendix A: Notices

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